Sandia National Laboratories

Sandia Health Benefits Plan for Employees

(Non-Represented Employees)

Effective: January 1, 2009

(OPEIU-Represented Employees)

Effective: March 1, 2009

Summary Plan Description

Important

This Summary Plan Description (including documents incorporated by reference) applies to non-represented employees, effective January 1, 2009, and to OPEIU-represented employees, effective March 1, 2009. Health benefits for employees whose employment is governed by the Metal Trades Council (MTC) and Security Police Association (SPA) are described in the Summary Plan Descriptions in effect prior to January 1, 2009. Health benefits for retirees are governed by the Sandia Health Benefits Plan for Retirees Summary Plan Description.

The Sandia Health Benefits Plan for Employees is maintained at the discretion of Sandia and is not intended to create a contract of employment and does not change the at-will employment relationship between you and Sandia. The Sandia Health Benefits Plan for Employees is expected to continue indefinitely. However, the Sandia Board of Directors (or designated representative) reserves the right to amend (in writing) any or all provisions of the Sandia Health Benefits Plan for Employees, and to terminate (in writing) the Sandia Health Benefits Plan for Employees at any time without prior notice, subject to applicable collective bargaining agreements. If the Plan is terminated, coverage under the Plan for you and your dependents will end, and payments under the Plan will generally be limited to covered expenses incurred before the termination.

The Sandia Health Benefits Plan for Employees' terms cannot be modified by written or oral statements to you from human resources representatives or other personnel**.**

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Contents

Section 1. Introduction

This Summary Plan Description (SPD) is intended to provide a summary of the principal features of the Sandia Health Benefits Plan for Employees. Additional information about component Programs included in the Sandia Health Benefits Plan for Employees is found in Appendix A of this document. These component Programs include the UnitedHealthcare (UHC) Premier PPO Program, the UHC Standard PPO Program, the CIGNA In-Network Program, the Kaiser HMO, the Dental Care Program, and the Vision Care Program. The Program materials referenced in Appendix A of this document, together with updates (for example, Summaries of Material Modifications and open enrollment materials) are hereby incorporated by reference into this SPD. For detailed information on the Programs, refer to the Program Summaries.

This SPD should be read in connection with the Program Summaries. (See Appendix A for a list of the Program Summaries.) The Program Summaries are provided by the insurance companies, HMOs and service providers. If there is ever a conflict or a difference between what is written in this SPD and the Program Summaries with respect to **the specific benefits provided**, the Program Summaries shall govern unless otherwise provided by any federal and state law. If there is a conflict between the Program Summaries and this SPD with respect to **the legal compliance requirements of ERISA and any other federal law**, this SPD will rule.

In general, this Summary Plan Description will cover eligibility; events allowing enrollment and disenrollment; Program premiums; general information; coordination of benefits; claims and appeals information; when coverage ends; continuation of group health coverage; and your rights under ERISA for the medical, dental, and vision Programs offered by Sandia to its non-represented and OPEIU-represented employees. Specific Program information will be covered in the applicable Program materials.

Certain capitalized words in this SPD have special meaning. These words have been defined in Section 12, Definitions.

To receive a paper copy of this SPD (including Program Summaries and other documents incorporated by reference), please contact Sandia HBE Customer Service at 505-844-HBES (4237) or email https://hbe.sandia.gov. This SPD (including documents incorporated by reference) also is available electronically at http://www.sandia.gov/resources/emp-ret/spd/index.html.

This SPD will continue to be updated. Please check back on a regular basis for the most recent version.

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Section 2. Summary of Changes

This section highlights the changes made to the Sandia Health Benefits Plan for Employees.

The following changes are effective January 1, 2009 for both non-represented and OPEIU-represented employees:

- Newly hired or rehired employees have 30 calendar days, instead of 31 calendar days, to enroll in the medical, dental, and vision Programs.
- Eligibility appeals process has been revised to include both a formal and informal review process.
- Subrogation and reimbursement rights section has been revised, as found under Injury or Illness Alleged to be Caused by a Third Party, page 7.3.

The following changes are effective January 1, 2009 for non-represented employees, and, March 1, 2009, for OPEIU-represented employees:

- Dependent eligibility rules have changed (refer to Section 3, Eligibility).
- Year-round student interns (other than those on fellowship programs) are limited to enrolling in the UHC Standard PPO Program.
- Summer student interns, university faculty sabbatical, and faculty sabbatical employees are no longer eligible for medical coverage.
- New Class II dependents cannot be enrolled in the Sandia medical Programs. Eligible Class II dependents previously enrolled will be allowed to continue enrollment. If the Class II dependent is subsequently dropped from coverage, no re-enrollment will be allowed. Annual verification is required.
- Salary tiers for premium-sharing changed from three tiers to four tiers.
- Provisions for premium-sharing for part-time employees have been changed.
- Overall medical premium-sharing increased from 18% to 19%.
- The Dental Expense Plan and Dental Deluxe Plan were replaced with the Dental Care Plan. Employees pay 20% of the cost.

The following changes have various effective dates as noted below for non-represented and OPEIU-represented employees:

- Non-represented employees hired or Rehired on or after January 1, 2009 will pay the full (100%) experience-rated premium for retiree medical and dental coverage. OPEIU-represented employees hired or Rehired on or after July 1, 2009 will pay the full (100%) experience-rated premium for retiree medical and dental coverage.
- Effective April 1, 2009, for both non-represented and OPEIU-represented employees, HIPAA Special Enrollment Period information has been updated for new provisions.
- Effective March 1, 2009, for both non-represented and OPEIU-represented employees, premium-share for Leaves of Absence have been revised.

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Section 3. Eligibility Information

This section outlines employee eligibility for the medical, dental, and vision Programs, dependent eligibility guidelines, information on Qualified Medical Child Support Orders (QMCSO), proof of dependent status, events causing dependent ineligibility, consequences of not disenrolling ineligible dependents in the required time frame, special rules for Medicare primary covered members, and provision for covered members with End Stage Renal Disease.

Employee Eligibility

The following table outlines the eligibility for employees for medical, dental, and vision benefits:

Classification	Medical Benefits	Dental Benefits	Vision Benefits
Regular full- or part-time employee	Yes	Yes	Yes
Limited-term full-or part-time exempt employee	Yes	Yes	Yes
Limited-term full- or part-time non-exempt employee	Yes	Yes	Yes
Full- or part-time Post Doctoral Appointee	Yes	Yes	Yes
Year-round student intern employee (with the exception of student intern fellowship programs)	UHC Standard PPO only if enrolled in a post-secondary educational program and not covered by another medical plan	No	No
Summer student intern employee	No	No	No
Recurrent employee	No	No	No
Faculty Sabbatical Appointee employee	No	No	No

For purposes of coverage under the Sandia medical, dental, and vision Programs, an employee is eligible only if:

- He/she has satisfied all requirements for coverage under the Sandia Health Benefits Plan for Employees.
- Sandia withholds required federal, state, or FICA taxes from his/her paycheck.

EXCEPTIONS:

1. An employee receiving benefits under Sandia's Job Incurred Accident Disability Plan who does not have taxes withheld by Sandia from his/her paycheck, but who otherwise satisfies the eligibility requirements of the Sandia Health Benefits Plan for Employees, is an "employee" for purposes of coverage under the Sandia Health Benefits Plan for Employees.
2. An employee who is on a Sandia-approved leave of absence, as evidenced by the written approval then required for such leave, who otherwise satisfies the eligibility requirement of the Sandia Health Benefits Plan for Employees, is an "employee" for purposes of coverage under the Sandia Health Benefits Plan for Employees.

No Duplicate Coverage

You may not be covered by a medical, dental, or vision Program provided by Sandia as an employee or retiree and as an eligible family member of another primary covered Sandia employee or retiree at the same time.

Dependents of dual Sandians who have legally separated, divorced, had an annulment, or dissolved domestic partnership cannot be covered under both parent's medical, dental, or vision Programs. For example, if a child's parents both work at Sandia and each parent enrolls in a separate medical Program, the child cannot be covered under both parent's medical Program. If you are covered as an eligible family member and then become eligible for coverage under the Sandia medical, dental, or vision benefits, you have two options:

- Waive the employee coverage, or
- Make sure that the Sandia employee or retiree who has been covering you disenrolls you from his or her Sandia medical, dental, or vision Program before you enroll yourself.

If Sandia discovers double coverage, Sandia reserves the right to:

- Cancel the later enrollment.
- Retroactively terminate dependent coverage, effective the end of the month in which the dependent became ineligible.
- Not be liable to refund any applicable premium paid by you during the ineligible period.

- Hold the primary covered member personally liable to refund to Sandia all health benefit claims or premiums (for insured Programs) rendered during the ineligible period.
- Take employment disciplinary action up to and including termination.

Eligible Dependents

This section outlines eligibility for dependent coverage under the medical, dental, and vision Programs.

Benefits paid under a group health plan for your covered dependents who are not a qualifying child or qualifying relative under the Internal Revenue Code (IRC) causes you to receive additional compensation as taxable wages. You are required to declare as taxable income the value (imputed income) of the coverage for your Non-Qualifying Dependent(s). Imputed income is not a pay increase. It is the value of Sandia's contributions for health plan coverage for dependents who do not meet the criteria as a qualifying child or qualifying relative. The imputed income will be added to your gross income and will be subject to income tax and may be subject to FICA Social Security and income taxes. This amount will be reported on your annual W-2 from Sandia or other appropriate reporting tax form. If you determine that one or more of your covered dependents are Non-Qualifying Dependent(s), you need to contact Sandia HBE to arrange for the imputed income to be added to your gross income.

IMPORTANT: It is your responsibility to notify the Benefits Department if your covered dependent does not meet the qualifying child or qualifying relative criteria. See Internal Revenue Service (IRS) Publication 502 for help in determining who is a qualifying child or a qualifying relative. Should the Internal Revenue Service audit your tax return and determine you have obtained tax benefits for which you are not eligible, you might be responsible for any overdue taxes, interest, and penalties.

Sandia provides coverage for two classes of dependents: Class I dependents and Class II dependents (enrolled prior to January 1, 2009 for non-represented employees, or prior to March 1, 2009, for OPEIU-represented employees).You must enroll your Class I dependent within 31 calendar days (60 calendar days for a birth, adoption, or placement for adoption) of the event creating eligibility. Refer to Section 4, Mid-Year Enrollment/Disenrollment Events, for enrollment information and coverage effective dates. If you enroll your dependent(s) for coverage effective prior to the 17th of the month, you are required to pay the applicable cost-share amount for the month for coverage under the applicable Sandia medical and dental Programs. If you enroll your dependent(s) for coverage on the 17th of the month or later, you are not required to pay the cost-share amount for the month for coverage under the applicable Sandia medical and dental Programs.

Class I Dependents

If you enroll for coverage, you may also enroll your eligible dependents as a Class I dependent in your medical, dental, and/or vision Program as outlined in the table below:

Dependent Category	Eligibility	Must meet all applicable requirements
Please note that Sandia will generally disenroll your dependent upon turning age 24 and your dependent will have coverage only through the end of the month. If your dependent was not automatically disenrolled, please notify the Sandia Benefits Department to disenroll. Refer to Section 10, Continuation of Health Group Coverage for information on continuing coverage.		
Spouse	To any age	• Not legally separated or divorced from you **Note:** An annulment also makes the spouse ineligible for coverage.
Same-gender domestic partner	To any age	• Is the same gender as you • Shares significant financial resources and dependencies • Has resided with you continuously for at least six months in a sole-partner relationship that is intended to be permanent (a marriage certificate with your same-gender partner can be substituted for this requirement) • Is not married to someone of the opposite gender • Is not related to you by blood (e.g., brothers, sisters, parents, children, cousins, nieces, uncles) • Is at least 18 years of age
Your or your same-gender domestic partner's natural child, child placed for adoption or adopted child, or a child for whom you have legal guardianship	To age 24	• Unmarried
Your Stepchild	To age 19	• Unmarried • Lives with you at least 50% of the calendar year
	19 to age 24	• Unmarried • Full-time student
Your or your same-gender domestic partner's natural child, legally adopted child, or child for whom you have legal guardianship who is recognized as an alternate recipient under a Qualified Medical Child Support Order (refer to page 3-6).	To age 24	• Unmarried • If a court decree requires the primary covered member to provide coverage

Dependent Category	Eligibility	Must meet all applicable requirements
Your or your same-gender domestic partner's over age disabled child	Age 24 or older	• Unmarried • Permanently and totally disabled according to the medical claims administrator(1) • Unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than one year according to the claims administrator • Who lives with you, in an institution or in a home that you provide • Who is financially dependent on you **Note:** Kaiser Permanente has the following additional requirements: 1. Dependent is incapable of self-sustaining employment because of mental retardation or physical handicap that occurred prior to reaching the age limit for dependents 2. Receive substantially all of their support and maintenance from you and your spouse 3. You submit proof of their incapacity within 31 days after Kaiser requests it
(Kaiser HMO only) Other unmarried dependent persons	To age 24	• He or she receives from you or your spouse all of his or her support and maintenance • He or she permanently resides with you • You or your spouse is the court-appointed guardian (or was before the person reached age 18) or whose parent is an enrolled dependent under your family coverage

(1) If only enrolled in both dental and vision, permanently and totally disabled status will be determined by the dental claims administrator.

Class II Dependents

Class II Dependents are eligible for coverage under the UHC Premier PPO or UHC Standard PPO if they were enrolled prior to January 1, 2009 for non-represented employees, or prior to March 1, 2009, for OPEIU-represented employees. Class II dependents who are Medicare-primary due to age will be enrolled in the UHC Senior Premier PPO. Class II dependents are not eligible to receive substance abuse benefits.

IMPORTANT: If you disenroll your Class II dependent, you cannot re-enroll them.

Your Class II Dependent must satisfy all of the following conditions to continue coverage:

- Is unmarried (unless they are your or your spouse's or same-gender domestic partner's parent, step-parent, or grandparent).
- Is financially dependent on you.
- Has a total income, from all sources, of less than $15,000 per calendar year other than the support you provide.
- Has lived in your home, or one provided by you in the United States, for the most recent six months.

Note: If you have a Class II dependent who is studying at a school outside the United States and is expected to return home to the United States after completing those studies, the Class II dependent will be considered as residing in your home in the United States (provided that you are paying his/her living expenses while he/she is abroad and he/she meets the other qualifying criteria). The Class II dependent must have lived with you or in a home you provided for the previous six months before leaving to study abroad.

Qualified Medical Child Support Order (QMCSO)

Generally, your Sandia health benefits may not be assigned or alienated. However, an exception applies in the case of any child of a participant (as defined by ERISA) who is recognized as an Alternate Recipient in a Qualified Medical Child Support Order (QMCSO). A QMCSO is any judgment, decree, or order (including a court-approved settlement agreement) that is issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law, which has the force and effect of law in that state; that assigns to a child the right of a participant or beneficiary to receive benefits under an employer-provided health plan, regardless of with whom the child resides; and that Sandia has determined is qualified under the terms of ERISA and applicable state law. The Sandia Health Benefits Plan for Employees will comply with the terms of a QMCSO. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. Coverage under a Sandia medical, dental, and/or vision Program pursuant to a medical child support order will not become effective until Sandia determines that the order is a QMCSO. Sandia's Legal Organization will review the medical child support order to determine whether it meets the criteria for a QMSCO. If you have questions about or wish to obtain a copy of the procedures governing a QMCSO Determination (at no charge), contact Sandia Benefits HBE at 505-844-HBES (4237).

Proof of Dependent Status

To verify eligibility for your covered dependents under the Sandia Health Benefits Plan for Employees, Sandia, insurance carriers, third party administrators or other third parties designated by Sandia, may request documentation needed to verify the relationship, including but not limited to birth certificates, adoption records, marriage certificates, verification of domestic partnership, and tax documentation.

In addition, Sandia may request information from you regarding Medicare eligibility and enrollment, address information, and more. You are required to promptly provide the requested information.

Sandia reserves the right to disenroll employees and their covered dependents for failing to provide documentation when requested. In addition, employees who have ineligible dependents enrolled in the medical, dental, or vision Programs may be subject to other consequences as outlined under Consequences of Not Disenrolling Ineligible Dependents, page 3-8.

Events Causing Your Dependent to Become Ineligible

If your dependents do not meet the dependent eligibility criteria as required by the Sandia medical, dental, and vision Programs, they do not qualify for coverage and you must disenroll them. Coverage ends at the end of the month in which the dependent became ineligible.

The following events make your dependent(s) ineligible for coverage under a Sandia medical, dental, and/or vision Program and you must disenroll them within 31 calendar days following one or more of the following events:

If your dependent is:	Loss of eligibility occurs due to:
A spouse	• Divorce • Legal separation • Annulment • Death
A domestic partner	• Dissolution of domestic partnership • Death • Retirement of employee
A Class I dependent child	• Marriage • Turning age 24 • Dissolution of legal guardianship • No longer covered under a QMCSO • Dissolution of domestic partnership • Death
A Class I dependent stepchild	• Marriage • No longer living with you at least 50% of the calendar year if less than age 19 • No longer a full-time student if between 19 and 24 • No longer covered under a QMCSO

If your dependent is:	Loss of eligibility occurs due to:
	• Dissolution of domestic partnership • Death
A Class I dependent over age disabled child	• Marriage • Determination by Claims Administrator that the child is no longer eligible for disabled coverage • Child no longer lives with you or in an institution or home you provide • No longer financially dependent on you • No longer covered under a QMCSO • Dissolution of domestic partnership • Death
A Class II dependent child, step-child, grandchild, brother, sister	• Marriage • Has total income, from all sources, of $15,000 or more per calendar year (other than the support you provide) • No longer financially dependent on you • No longer lives in your home or one provided by you (in the United States) • No longer covered under a QMCSO • Dissolution of domestic partnership • Death
A Class II dependent parent, step-parent, or grandparent	• Has total income, from all sources, of $15,000 or more per calendar year (other than the support you provide) • No longer financially dependent on you • No longer lives in your home or one provided by you (in the United States) • Dissolution of domestic partnership • Death

Consequences of Not Disenrolling Ineligible Dependents

You must disenroll your ineligible dependent within 31 calendar days of the date that your dependent no longer meets the eligibility criteria for coverage under a Sandia medical, dental, or vision benefit. Refer to Section 4, "Mid-Year Enrollment/Disenrollment Events" for information on how to disenroll dependents.

If you do not disenroll your ineligible dependent, Sandia reserves the right to:

- Take employee disciplinary action up to and including termination for fraudulent use of the Sandia Health Benefits Plan for Employees.
- Take action that results in permanent loss of coverage for you and your dependents for fraudulent use of the Sandia Health Benefits Plan for Employees.
- Report the incident to the DOE Office of the Inspector General.
- Retroactively terminate dependent coverage, effective the end of the month in which the dependent became ineligible.

- Hold you personally liable to refund to Sandia all medical, dental, and vision benefits provided during the ineligible period including claims costs or monthly premiums.
- Terminate any rights to temporary, continued coverage under COBRA.

Sandia is not liable to repay you for any medical, dental, or vision monthly premium share(s) paid by you during the ineligible period.

Special Rules for Covered Medicare-Primary Members

If you or your spouse reach age 65, or you, your spouse, your same-gender domestic partner or your dependent become disabled and eligible for Medicare while you are actively employed at Sandia, you may continue primary coverage under a Sandia medical program while you are employed by Sandia, with the exception of those members who have End Stage Renal Disease as discussed below. However, domestic partners or dependents of domestic partners who reach the age of 65 and are eligible for Medicare, are considered as having Medicare as their primary medical coverage, even if enrolled as a dependent of an employee. Therefore, Sandia will enroll the domestic partner or dependent of a domestic partner in the applicable retiree medical program. Sandia will pay benefits as secondary payer, regardless of whether your domestic partner or domestic partner's dependents enroll in Medicare Parts A and B. You are required to notify the Sandia Benefits Department if your spouse, same-gender domestic partner, or covered dependent children or same-gender domestic partner's children become Medicare eligible due to disability.

You and/or your spouse and/or your dependent (if applicable) must be covered by Medicare Part A and B effective the first of the month after the month in which you retire. Your coverage under the Sandia Health Benefits Plan for Employees ends at the end of the month in which you retire.

IMPORTANT: If a covered member who is eligible for Medicare primary coverage (generally someone with ESRD who has already received 33 months of Medicare coverage or a domestic partner who attain the age of 65) is provided coverage on a primary basis under this or any other Sandia medical Program, the employee will be responsible for reimbursing Sandia for any ineligible claims.

Provision for Covered Members with End-Stage Renal Disease (ESRD)

Covered members may be eligible for Medicare primary medical coverage due to end-stage renal disease. Sandia medical benefits may continue as your primary coverage for the first 33 months (from the time you start dialysis), which includes the 30-month coordination period with Medicare as your secondary coverage. After the 30-month coordination period, Medicare will become your primary coverage. Sandia will pay benefits only as secondary payer for benefits

provisions under a Sandia medical Program, regardless of whether you or your covered dependent enrolled in Medicare Parts A and B. If you become Medicare primary due to ESRD while an active employee and you are enrolled in the Kaiser HMO Plan, you will have to disenroll and enroll in another medical program. You are required to notify the Sandia Benefits Department if your covered dependent becomes eligible for Medicare primary coverage.

IMPORTANT: If a covered member who is eligible for Medicare primary coverage (generally someone with ESRD who has already received 33 months of Medicare coverage or a domestic partner who attain the age of 65) is provided coverage on a primary basis under this or any other Sandia medical Program, the employee will be responsible for reimbursing Sandia for any ineligible benefits.

Section 4. Mid-Year Enrollment/Disenrollment Events

This section outlines those events that allow mid-year enrollment into or disenrollment from the Sandia medical, dental, and vision Programs.

When You Can Enroll

You can enroll yourself and/or your eligible dependents in your medical, dental, and/or vision Program:

- Upon becoming a new employee
- During the annual open enrollment
- Upon a mid-year election change event
- Upon a HIPAA Special Enrollment Period

> **Note:** Many of the change in status events also qualify under the HIPAA Special Enrollment Period (as discussed on page 6-3) for the medical and vision Programs. There may also be other events under HIPAA Special Enrollment Period not listed here that allow enrollment opportunities – refer to the HIPAA Special Enrollment Period on page 6-3) for more information.

When You Can Disenroll

You can disenroll yourself and/or your eligible dependents in your medical, dental, and/or vision Program:

- During the annual open enrollment
- Upon a mid-year election change event

Coverage for any eligible dependent is based on your coverage as an employee; therefore, if you drop coverage for yourself, you are also dropping coverage for all of your dependents.

If the disenrollment of a dependent child does not affect your premium-share amount, you can disenroll a dependent child at any time during the calendar year with coverage terminating the end of the month in which you submit the disenrollment form, however, the dependent is not eligible for COBRA coverage unless the disenrollment is caused by the dependent child's loss of eligibility for coverage.

IMPORTANT: If your covered dependent loses eligibility as outlined under Section 3, "Eligibility Information" and you do not disenroll that dependent within 31 calendar days, you are subject to certain consequences as outlined in the subsection entitled "Consequences of Not Disenrolling Ineligible Dependents" on page 3-8.

Enrolling as a New Employee

As a new employee, you can enroll yourself and any eligible Class I dependents in the medical, dental, and/or vision Programs on the Sandia internal web through HR Self-Service/Benefits/Benefits Enrollment.

IMPORTANT: You must submit your coverage selection within 30-calendar days of hire. Coverage will be retroactive to your date of hire. If you miss the 30 calendar day enrollment window, you will have to wait until the next Open Enrollment period to enroll and your coverage will be considered as waived.

Same-gender domestic partners and same-gender domestic partner's child(ren) enrollment is completed through the Enrollment/Disenrollment Packet (SF 4400-PKG). Mail the completed and signed applicable form(s) to Sandia Benefits, Attn: HBE, Mail Stop 1463. Mail form(s) in adequate time to be received by Benefits within the 30 calendar-day requirement for enrollment.

If you terminate employment with Sandia and are Rehired within 30 days after terminating employment (or if you return to employment after being terminated for less than 30 days), you and any covered dependents at time of disenrollment will automatically be reinstated to your medical, dental, and vision elections you had prior to termination.

Waiver of Coverage

Upon becoming a new employee, you have the option to waive coverage for yourself and your dependents. Coverage for any eligible dependent is based on your coverage as an employee; therefore, if you waive coverage for yourself, you are also waiving coverage for all of your dependents. Generally, if you waive coverage, the next opportunity for you to reinstate your coverage under a Sandia medical, dental, or vision Program will be during the annual Open Enrollment period Sandia holds each fall, with coverage becoming effective January 1 of the following year.

Enrolling/Disenrolling During Annual Open Enrollment

Every year in the fall you have the option to change your medical, dental, and/or vision coverage, waive coverage, enroll in coverage, and/or add or drop dependents. Open Enrollment is done through the web-based open enrollment system (except for same-gender domestic partner and his/her children). Elections made during Open Enrollment take effect January 1 of the following calendar year. If you do not make any changes during Open Enrollment, your current elections for medical, dental, and vision will carry into the next calendar year.

Mid-Year Election Change Events Allowing Enrollment/ Disenrollment

Generally, once you make an election, you cannot make a change until the next Open Enrollment period. However, certain events may allow mid-year enrollments into or disenrollments from the medical, dental, and/or vision Programs. These events are called mid-year election change events and fall into the following categories:

- Change in status events (see below for consistency rule)
- Certain judgments, decrees or orders
- Entitlement to Medicare or Medicaid
- Change in cost
- Change in coverage

> **Note:** Mid-year election change events, with the exception of moving into or out of the service area, generally DO NOT ALLOW you to change from one medical Program to another. These are typically only allowed only during the annual Open Enrollment period held each fall. However, if you experience a HIPAA Special Enrollment Period event, as outlined in Section 6, General Information, you may be eligible to select another medical Program.

A mid-year election change is permitted by Internal Revenue Code, Section 125, as long as the change in status event meets the consistency requirements of the federal legislation. A change in status event must meet the consistency requirement according to the two rules as follows:

- The change in status event must affect eligibility for coverage under the Sandia Health Benefits Plan for Employees or under a plan sponsored by the employer of your spouse or dependent. Eligibility for coverage is affected if you become eligible or ineligible for coverage or if the event results in an increase or decrease in the number of your dependents who may benefit from coverage under the Sandia Health Benefits Plan for Employees, and
- The election change must correspond with the change in status event.

Examples of the consistency requirement:

- An eligible dependent who is turning 19 and is enrolled under his non-Sandian mother's health plan will lose coverage as the health plan requires him to be a full-time student. As

he is losing eligibility under another health plan, so long as he meets the criteria to enroll in a Sandia medical, dental, or vision Program, he can enroll.

- An eligible dependent who is turning 19 and is enrolled under his non-Sandian mother's health plan will lose coverage as the health plan requires him to be a full-time student. In addition to enrolling the eligible dependent in the medical, dental and vision Programs, the employee also wants to enroll his spouse. This is not permissible as the election change does not correspond to the change in status event.
- An employee gets divorced and wants to disenroll his ex-wife from his medical, dental and vision benefits. This is allowable due to the loss of eligibility; however, the employee cannot disenroll his natural children as the children presumably do not lose eligibility for the medical, dental, and vision benefits because of the divorce.
- An eligible dependent who is 22 years old is enrolled in one of the Sandia medical Programs under his father. The dependent becomes a full-time student. Full-time student status is one of the criteria for the dependent's mother's employer group health plan for dependents over age 18. In this case, the dependent would be allowed to disenroll from the Sandia medical Program.

IMPORTANT: Enrollment/disenrollment requests must be submitted to the Sandia Benefits Department within 31 calendar days of the eligible mid-year election change event. You can also submit enrollment paperwork after the 31st calendar day but before the 61st calendar day of the event for a birth, an adoption, or a placement for adoption, however, the coverage effective date will not be retroactive. Documentation supporting the request can be submitted separately from the enrollment/disenrollment paper work but must be submitted within 60 calendar days of the event (except where otherwise noted). If the enrollment paperwork was submitted within the applicable time frame but no supporting documentation is received within the 60 day calendar day period, no enrollment will be done. If you miss the enrollment period, the next opportunity to enroll will be during the Open Enrollment period Sandia holds each fall, with coverage effective January 1 of the following calendar year.

The following table outlines the eligible mid-year election change events allowing mid-year enrollment or disenrollment in the medical, dental, and vision Programs. Many of the change in status events also qualify under the HIPAA Special Enrollment Period (as discussed in Section 6) for the medical and vision Programs. In addition, there may be other events under the HIPAA Special Enrollment Period not listed here that allow enrollment opportunities. Look at this table first to see if your mid-year event allows enrollment and who you may enroll. If you do not find your mid-year event and/or allowable change here, refer to the HIPAA Special Enrollment Period information to identify the enrollment opportunities under that provision.

Note:. HIPAA Special Enrollment Periods as outlined in Section 6 of this document apply to same-gender domestic partners, but Section 125 cafeteria

plan rules do not, which explains the different rules for same-gender domestic partners.

The table includes the allowable change, the documentation needed to support the change, and when coverage begins or ends (whichever is applicable):

Mid-Year Election Change Event	Allowable Change[1]	Supporting Documentation[2]	When Coverage Begins/ Ends
CHANGE IN STATUS EVENTS			
Change in Employee's Legal Marital/Domestic Partnership Status			
Marriage	You may enroll yourself, spouse, and any eligible dependent(s)	None	Coverage begins on the later of the date of the event creating eligibility or the date the Benefits Department receives completed paperwork
	You may disenroll yourself and any enrolled dependents who enroll in a Sandia-sponsored or non-Sandia-sponsored plan of the same type (e.g., medical, dental, vision)	You must provide documentation of enrollment in the non-Sandia-sponsored plan.	Coverage ends on the last day of the month in which the event takes place
Enter into same-gender domestic partnership under Sandia's coverage	If you are already enrolled, you may enroll your same-gender domestic partner and eligible same-gender domestic partner dependents	None	Coverage begins on the later of the date of the event creating eligibility or the date the Benefits Department receives completed paperwork.
Divorce, legal separation, annulment	You may enroll yourself and any eligible dependents who lose coverage	You must submit the Certificate of Creditable Coverage from previous medical insurance carrier	Coverage begins on the later of the date of the event creating eligibility, date of loss of coverage (medical and vision) or the date the Benefits Department receives completed paperwork

1 If you are both Sandia employees, please note that if one of you loses eligibility due to an event, that event may qualify as a mid year enrollment event for the person who lost eligibility. Any permitted change is subject to the No Duplicate Coverage provisions on page 3-2.

2 Refer to Proof of Dependent Status in Section 3, Eligibility Information.

Mid-Year Election Change Event	Allowable Change[1]	Supporting Documentation[2]	When Coverage Begins/ Ends
	You must disenroll spouse	You must submit the first page of divorce decree, legal separation papers, or annulment papers	Coverage ends on the last day of the month in which the dependent became ineligible
Dissolution of same-gender domestic partnership under Sandia's coverage	You must disenroll same-gender domestic partner and children of same-gender domestic partner	You must complete the Declaration of Termination of Domestic Partnership form	Coverage ends on the last day of the month in which dependent became ineligible
Dissolution of Domestic Partnership under non-Sandia coverage	You may enroll yourself and any eligible dependent(s) in a medical and/or vision Program who lose coverage	You must submit the Certificate of Creditable Coverage from previous medical insurance carrier	Coverage begins on the later of the date of the event creating eligibility, the date of loss of coverage, or the date the Benefits Department receives completed paperwork
Death of Spouse/ Domestic Partner	You may enroll yourself and any eligible dependent(s) who lose coverage	You must submit the Certificate of Creditable Coverage from previous medical insurance carrier	Coverage begins on the later of the date of the event creating eligibility, the date of loss of coverage, or the date the Benefits Department receives completed paperwork
	You must disenroll spouse	None	Coverage ends on the date of death
Death of Same-Gender Domestic Partner	You must disenroll same-gender domestic partner	None	Coverage ends on the date of death
Change in the Number of Employee Dependents			
Birth	You may enroll yourself, spouse (or same-gender domestic partner and his/her child(ren)) , newborn, and any eligible dependents	None	Retroactive coverage to the date of the birth if enrolled within 31 calendar days of the birth. You can also enroll after 31 calendar days but before the 61st calendar day from the date of birth, however, coverage will be effective on the date the paperwork is received by the Benefits Department.

Mid-Year Election Change Event	Allowable Change[1]	Supporting Documentation[2]	When Coverage Begins/ Ends
Adoption or placement for adoption[3]	You may enroll yourself, spouse (or same-gender domestic partner and his/her child(ren)), newly adopted eligible children, and any other eligible dependent(s)	You must submit the official placement agreement and/or official adoption papers upon enrollment.	Retroactive coverage to the date of the adoption or placement for adoption if enrolled within 31 calendar days of the adoption. You can also enroll after 31 calendar days but before the 61st calendar day from the date of adoption or placement for adoption, however, coverage will be effective on the date the paperwork is received by the Benefits Department.
Legal Guardianship	You may enroll yourself, spouse (or same-gender domestic partner and his/her child(ren)), newly eligible children, and any other eligible dependent(s)	You must submit the legal guardianship court papers granting permanent custody upon enrollment.	Coverage begins on the later of the date of the event creating eligibility or the date the Benefits Department receives completed paperwork
Death of dependent (other than spouse or same-gender domestic partner)	You must disenroll dependent	None	Coverage ends on the date of death
Change in Dependent Status			
Event by which dependent(s) satisfy eligibility requirements	You may enroll newly eligible dependents(s)	None (with the exception of disabled child – refer to Section 3, Eligibility Information)	Coverage begins on the later of the date of the event creating eligibility or the date the Benefits Department receives completed paperwork
Event by which dependent ceases to satisfy eligibility requirements	You must disenroll dependent	None	Coverage ends on the last day of the month in which dependent became ineligible

[3] Medical expenses of the child before adoption, including the birth mother's prenatal, postnatal, and delivery charges, are not covered

Mid-Year Election Change Event	Allowable Change[1]	Supporting Documentation[2]	When Coverage Begins/ Ends
Change in Employment Status of Spouse, Same-Gender Domestic Partner, or Dependent that Affects Eligibility			
Spouse (or same-gender domestic partner or his her child(ren)) or eligible dependent(s) terminates employment or retires	You may enroll yourself, spouse (or same-gender domestic partner or his/her child(ren)) or eligible dependent(s) who lose coverage	You must submit the Certificate of Creditable Coverage from previous medical insurance carrier	Coverage begins on the later of the date of the event creating eligibility, the date of loss of coverage or the date the Benefits Department receives completed paperwork
Spouse or eligible dependent(s) commences employment	You may disenroll yourself, spouse, and/or enrolled dependent(s) who enroll in a Sandia-sponsored or non-Sandia-sponsored plan of the same type (e.g., medical, dental, vision)	You must provide documentation of enrollment in the non-Sandia-sponsored plan.	Coverage ends on the last day of the month in which the event takes place
Same-gender domestic partner commences employment	You may only disenroll your same-gender domestic partner and/or child(ren) of same-gender domestic partner	None	Coverage ends on the last day of the month in which the event takes place
Spouse (or same-gender domestic partner or his/her child(ren)), or eligible dependent(s) goes on strike or lockout	You may enroll yourself, spouse (or same-gender domestic partner or his/her child(ren)), or dependent(s) who lose coverage	You must submit the Certificate of Creditable Coverage from previous medical insurance carrier	Coverage begins on the later of the event creating eligibility, the date of the loss of coverage or the date the Benefits Department receives completed paperwork
Spouse or eligible dependent(s) returns from strike or lockout	You may disenroll yourself, spouse, or dependent(s) who enroll in a Sandia-sponsored or non-Sandia-sponsored plan of the same type (e.g., medical, dental, vision)	You must provide documentation of enrollment in the non-Sandia-sponsored plan.	Coverage ends on the last day of the month in which the event takes place
Same-gender domestic partner returns from strike or lockout	You may only disenroll your same-gender domestic partner and/or child(ren) of same-gender domestic partner	None	Coverage ends on the last day of the month in which the event takes place

Mid-Year Election Change Event	Allowable Change[1]	Supporting Documentation[2]	When Coverage Begins/ Ends
Spouse (or same-gender domestic partner or his/her child(ren)) or eligible dependent(s) commences an unpaid leave of absence	You may enroll yourself, spouse (or same-gender domestic partner or his/her child(ren)) or dependent(s) who lose coverage	You must submit the Certificate of Creditable Coverage from previous medical insurance carrier	Coverage begins on the later of the date of the event creating eligibility, the date of the loss of coverage or the date the Benefits Department receives completed paperwork
Spouse or eligible dependent(s) returns from an unpaid leave of absence	You may disenroll yourself, spouse, or dependent(s) who enroll in a Sandia-sponsored or non-Sandia-sponsored plan of the same type (e.g., medical, dental, vision)	You must provide documentation of enrollment in the non-Sandia-sponsored plan.	Coverage ends on the last day of the month in which the event takes place
Same-gender domestic partner returns from an unpaid leave of absence	You may only disenroll your same-gender domestic partner and/or child(ren) of same-gender domestic partner	None	Coverage ends on the last day of the month in which the event takes place
Spouse (or same-gender domestic partner or his/her child(ren)) or eligible dependent(s) have a change in work hours that makes them lose coverage	You may enroll yourself, spouse (or same-gender domestic partner or his/her child(ren)) or eligible dependent(s) who lose coverage	You must submit the Certificate of Creditable Coverage from previous medical insurance carrier	Coverage begins on the later of the date of the event creating eligibility, the date of loss of coverage or the date the Benefits Department receives completed paperwork
Spouse or eligible dependent(s) have a change that makes them eligible for other coverage	You may disenroll yourself, spouse, or dependent(s) who enroll in a Sandia-sponsored or non-Sandia-sponsored plan of the same type (e.g., medical, dental, vision)	You must provide documentation of enrollment in the non-Sandia-sponsored plan.	Coverage ends on the last day of the month in which the event takes place

Mid-Year Election Change Event	Allowable Change[1]	Supporting Documentation[2]	When Coverage Begins/ Ends
Same-gender domestic partner (or his/her child(ren)) has a change in work hours that makes them eligible for other coverage	You may only disenroll your same-gender domestic partner and/or child(ren) of same-gender domestic partner	None	Coverage ends on the last day of the month in which the event takes place
Spouse (or same-gender domestic partner or his/her child(ren)) or eligible dependent has a change in work site that makes them lose coverage	You may enroll yourself, spouse (or same-gender domestic partner or his/her child(ren)), or dependent(s) who lose coverage	You must submit the Certificate of Creditable Coverage from previous medical insurance carrier	Coverage begins on the later of the event creating eligibility, the date of the loss of coverage or the date the Benefits Department receives completed paperwork
Spouse or eligible dependent has a change in work site that makes them eligible for other coverage	You may disenroll yourself, spouse, or dependent(s) who enroll in a Sandia-sponsored or non-Sandia-sponsored plan of the same type (e.g., medical, dental, vision)	You must submit documentation of enrollment in the non-Sandia-sponsored plan.	Coverage ends on the last day of the month in which the event takes place
Same-gender domestic partner (or his/her child(ren)) has a change in work site that makes them eligible for coverage	You may only disenroll your same-gender domestic partner and/or child(ren) of same-gender domestic partner	None	Coverage ends on the last day of the month in which the event takes place
Change in Employment Status of Employee			
Employee has a change in work hours from 20 hours per week to 21 or more hours per week	You may enroll yourself, spouse (or same-gender domestic partner and his/her child(ren)) and eligible dependent(s)	None	Coverage begins on the later of the event creating eligibility or the date the Benefits Department receives completed paperwork
Employee has a change in work hours from 21 or more hours per week to 20 hours per week	You may disenroll yourself, spouse (or same-gender domestic partner and his/her child(ren)) or dependent(s)	None	Coverage ends at the end of the month in which the event takes place

Mid-Year Election Change Event	Allowable Change[1]	Supporting Documentation[2]	When Coverage Begins/ Ends
Employee commences leave of absence	You may disenroll yourself, spouse (or same-gender domestic partner and his/her child(ren)) or dependent(s)	None	Coverage ends on the last day of the month in which the event takes place
Employee returns from a leave of absence	You may enroll yourself, spouse (or same-gender domestic partners and his/her child(ren)) and eligible dependent(s)	None	Coverage begins on the later of the event creating eligibility or the date the Benefits Department receives completed paperwork
Employee goes on strike or lockout	You may disenroll yourself, spouse (or same-gender domestic partner and his/her child(ren)) or dependent(s)	None	Coverage ends on the last day of the month in which the event takes place
Employee returns from a strike or lockout	You may enroll yourself, spouse (or same-gender domestic partners and his/her child(ren)) and eligible dependent(s)	None	Coverage begins on the later of the event creating eligibility or the date the Benefits Department receives completed paperwork
Employee goes on FMLA absence	You may disenroll yourself, spouse (or same-gender domestic partner and his/her child(ren)) or dependent(s)	None	Coverage ends on the last day of the month in which the event takes place
Employee returns from an FMLA absence	You may enroll yourself, spouse (or same-gender domestic partners and his/her child(ren)) and eligible dependent(s)	None	Coverage begins on the later of the event creating eligibility or the date the Benefits Department receives completed paperwork

Mid-Year Election Change Event	Allowable Change[1]	Supporting Documentation[2]	When Coverage Begins/ Ends
Change in Residence			
Spouse (or same-gender domestic partner or his/her child(ren)) and any eligible dependent(s) who move outside of their medical plan Service Area	You may enroll yourself, your spouse (or same-gender domestic partner or his/her child(ren)) and any eligible dependent(s) who lose coverage if move outside of a service area	You must submit the Certificate of Creditable Coverage from previous medical insurance carrier	Coverage begins on the later of the event creating eligibility, the date of the loss of coverage or the date the Benefits Department receives completed paperwork
Spouse and any eligible dependent(s) who move within a Service Area of their medical plan	You may disenroll yourself, your spouse (or same-gender domestic partner or his/her child(ren)) and any eligible dependent(s) who enroll in a medical plan upon moving into the service area	You must submit documentation of enrollment in the non-Sandia-sponsored plan.	Coverage ends on the last day of the month in which the event takes place
Same-gender domestic partner (or his/her child(ren) move within a Service Area of their medical plan	You may only disenroll your same-gender domestic partner and/or child(ren) of same-gender domestic partner	None	Coverage ends on the last day of the month in which the event takes place
CERTAIN JUDGMENTS, DECREES OR ORDERS			
Judgment, decree or order which resulted from a divorce, legal separation, annulment, or change in legal custody, and must meet the requirements of a QMCSO	You may enroll the eligible dependent(s) consistent with the judgment, decree, or order	You must submit the official judgment, decree or order upon enrollment	Coverage begins on the later of the event creating eligibility, the date of the loss of coverage or the date the Benefits Department receives completed paperwork
	You may disenroll the eligible dependent(s) consistent with the judgment, decree, or order		Coverage ends on the last day of the month in which the event takes place

Mid-Year Election Change Event	Allowable Change[1]	Supporting Documentation[2]	When Coverage Begins/ Ends
CHANGE IN MEDICARE OR MEDICAID ENTITLEMENT			
Employee, spouse (or same-gender domestic partner or his/her child(ren)), and/or eligible dependent(s) loses Medicare or Medicaid eligibility (other than coverage for pediatric vaccines only)	You may enroll yourself, spouse (or same-gender domestic partner or his/her children), and any eligible dependent(s) who lose coverage	You must submit documentation from Medicare or Medicaid of loss of eligibility.	For those employees who are currently enrolled in the applicable medical Program or new enrollees, coverage at the applicable cost begins on the date indicated in the Open Enrollment materials.
Employee, spouse, and/or eligible dependent(s) gains Medicare or Medicaid eligibility (other than coverage for pediatric vaccines only)	You may disenroll yourself, spouse (or same-gender domestic partner or his/her child(ren)) and any eligible dependent(s) who enroll in Medicare or Medicaid	You must submit documentation from Medicaid or Medicare of enrollment	Coverage ends on the last day of the month in which the event takes place
Same-gender domestic partner gains Medicare or Medicaid eligibility (other than coverage for pediatric vaccines only)	You may only disenroll your same-gender domestic partner and/or child(ren) of same-gender domestic partner	None	Coverage ends on the last day of the month in which the event takes place
CHANGE IN COST			
Sandia significantly decreases the cost of a medical Program (as determined by Sandia)	You may elect the medical Program with the significant decrease in cost for you and your enrolled dependent(s)	None	Coverage begins on the date the Benefits Department receives completed paperwork
Sandia significantly increases the cost of a medical Program (as determined by Sandia)	You may select another medical Program through Sandia or select another employer-provided medical Program with similar coverage (e.g., a Program for which your spouse is eligible)	None	For those employees who are currently enrolled in the applicable medical Program or new enrollees, coverage at the applicable cost begins on the date indicated in the Open Enrollment materials.

Mid-Year Election Change Event	Allowable Change[1]	Supporting Documentation[2]	When Coverage Begins/ Ends
CHANGE IN COVERAGE			
Employee, spouse (or same-gender domestic partner or his/her child(ren)), or eligible dependent(s) dis-enroll from an employer group plan during the open enrollment period that operates on a plan year other than a calendar year	You may enroll yourself, spouse (or same-gender domestic partner or his/her child(ren)), or eligible dependent(s) who lose coverage	You must submit the Certificate of Creditable Coverage from previous medical insurance carrier	Coverage begins on the later of the event creating eligibility, the date of the loss of coverage or the date the Benefits Department receives completed paperwork
Spouse or eligible dependent(s) enrolls in an employer group plan during the open enrollment period that operates on a plan year other than a calendar year	You may disenroll yourself, spouse, or dependent(s) who enroll in a non-Sandia-sponsored plan of the same type (e.g., medical, dental, vision)	You must submit documentation of enrollment in the non-Sandia-sponsored plan.	Coverage ends on the last day of the month in which the event takes place
Same-gender domestic partner (or his/her child(ren)) enrolls in an employer group plan during the open enrollment period that operates on a plan year other than a calendar year	You may only disenroll your same-gender domestic partner and/or child(ren) of same-gender domestic partner	None	Coverage ends on the last day of the month in which the event takes place

Mid-Year Election Change Event	Allowable Change[1]	Supporting Documentation[2]	When Coverage Begins/ Ends
Spouse (or same-gender domestic partner or his/her child(ren)) or eligible dependent(s)' employer eliminates a medical plan during the year	You may enroll yourself, spouse (or same-gender domestic partner or his/her child(ren)), and eligible dependent(s) who lose coverage	You must submit the Certificate of Creditable Coverage from previous medical insurance carrier	Coverage begins on the date the Benefits Department receives completed paperwork
Spouse or eligible dependent(s)' employer offers a new medical plan during the year	You may disenroll yourself, spouse (or same-gender domestic partner and his/her child(ren)), or dependent(s) who enroll in a non-Sandia-sponsored plan of the same type (e.g., medical, dental, vision)	You must submit documentation of enrollment in the non-Sandia-sponsored plan.	Coverage ends on the last day of the month in which the event takes place
Same-gender domestic partner's (or his/her child(ren)) employer offers a new medical plan during the year	You may only disenroll your same-gender domestic partner and/or child(ren) of same-gender domestic partner	None	Coverage ends on the last day of the month in which the event takes place
Sandia eliminates or significantly reduces (as determined by Sandia) benefits under one of the medical Programs that covers you in the middle of the Plan year	You may elect a different medical Program for you and your enrolled dependent(s)	None	Coverage begins on the date the Benefits Department receives completed paperwork

Mid-Year Election Change Event	Allowable Change[1]	Supporting Documentation[2]	When Coverage Begins/ Ends
Sandia adds a new medical Program or coverage under an existing medical Program is improved significantly (as determined by Sandia) during the Plan year	You may elect the new medical Program or the improved medical Program for you and your enrolled dependent(s)	None	Coverage begins on the date the Benefits Department receives completed paperwork

Enrolling Upon a HIPAA Special Enrollment Period (SEP)

Under the special enrollment provisions of HIPPA, you may be eligible, in certain situations, to enroll in a Sandia medical or vision Program during the year, if when coverage was previously offered, you had coverage under any group or individual medical or vision plan, and you declined coverage through Sandia. This right extends to you and all eligible dependents. Refer to Section 6, General Information. Many of these events also qualify under the mid-year election change events as outlined above (for example, the birth of a child is both a mid-year Change in Status Event as well as qualifies under the HIPAA Special Enrollment Period).

How to Enroll

- Complete the applicable sections of the Enrollment/Disenrollment Packet (SF 4400-PKG)
- Retain a copy for your files
- Mail the original, early enough to meet the required enrollment time frame, to the Sandia Benefits Department (Attn: HBE, MS1463).
- Same-gender domestic partners and domestic partner's children are enrolled by completing the applicable sections of the Enrollment/Disenrollment Packet (SF 4400-PKG).
- If supporting documentation is required, submit this either upon enrollment (if required) or within 60 calendar days of the mid-year enrollment event.

Benefit forms are available on Sandia's website under Corporate Forms/Benefits or by contacting Sandia Benefits HBE at 505-844-HBES (4237).

How to Disenroll

- Complete the applicable sections of the Enrollment/Disenrollment Packet (SF 4400-PKG)
- Retain a copy for your files

- Mail the original, early enough to meet the 31 calendar day criteria, to the Sandia Benefits Department (Attn: HBE, MS1463).
- Same-gender domestic partners and domestic partner's children are disenrolled by completing the Declaration of Termination of Domestic Partnership form.

Benefit forms are available on Sandia's website under Corporate Forms/Benefits or by contacting Sandia Benefits HBE at 505-844-HBES (4237).

Sandia abides by a federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 in which temporary continued coverage is provided to dependents who would otherwise lose group coverage due to specified events. Refer to Section 10, "Continuation of Group Health Coverage" for more information.

Note: Contact Sandia Benefits at 505-844-HBES (4237) for COBRA information.

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Section 5. Program Premiums

This section outlines how premiums are charged according to the various classifications of members who are eligible for coverage under the medical and dental Programs. Vision coverage is entirely paid by Sandia (except you must pay 50% if you work 20 hours a week on a part-time schedule).

Employee Premium

All employees pay a monthly premium (also referred to as a premium-share) for coverage under the medical or dental Programs. If your coverage under medical or dental is terminated, premiums are deducted for the full month since coverage under the medical and dental Programs are through the last day of the month in which you terminate.

Premiums are deducted, on a pre-tax basis through the Pre-Tax Premium Plan, from your biweekly paycheck in two equal installments each month. Premiums are deducted before any federal, state (in most states), or FICA taxes are deducted, thereby reducing your taxable income. Because the deductions are taken out before Social Security taxes are calculated, there may be a small impact on your Social Security retirement/disability benefits. Dependents that are not a qualifying child or qualifying relative under the Internal Revenue Code are also eligible to have premiums taken on a pre-tax basis. However, the employee will be subject to imputed income on the applicable full premium amount (contributions paid by the employee as well as contributions paid by Sandia). Refer to "Eligible Dependents" under Section 3, Eligibility Information, and "Domestic Partner Premium" in this Section for additional information.

Note: Due to IRS regulations, premiums for health insurance coverage are not eligible for reimbursement under the Health Care Flexible Spending Account. In addition, you cannot take your pre-tax health care premiums as a deduction on your income tax return.

If your effective coverage date is prior to the 17th of the month, you are required to pay the applicable cost-share amount for the month in which you became eligible for coverage under the applicable Sandia medical and dental Programs. If your effective coverage date is on the 17th of the month or later, you are not required to pay the cost-share amount for the month in which you became eligible for coverage under the applicable Sandia medical and dental Programs.

The premiums for coverage under the medical and dental Programs are provided during the Open Enrollment period Sandia holds each fall prior to the start of the plan year. You may also find them on http://www.sandia.gov/resources/emp-ret/index.html or you can contact Sandia Benefits HBE at 505-844-HBES (4237) for premium-share information for coverage.

Note: If there is an insignificant (as determined by Sandia) cost increase or decrease for a medical, dental, or vision Program during the year, and it requires a corresponding change in your premium-share amount, Sandia will automatically increase or decrease your contributions on a prospective basis to reflect the change.

Medical Premiums

For medical coverage, your monthly premium payments are set according to your base salary tier, coverage tier, and the medical coverage you elected. Employees pay, on average, 19% of the experience-rated premiums.

Coverage tiers:

- Employee Only
- Employee and child(ren)
- Employee and Spouse
- Employee, Spouse, and child(ren)

Salary tiers (as of January 1):

- Tier 1 – Base salary of up to $50,000
- Tier 2 – Base salary of $50,001 to $80,000
- Tier 3 – Base salary of over $80,001 to $130,000
- Tier 4 – Base salary of $130,001 or above

The premium share for the calendar year is based on your base salary as of January 1 at the start of the new plan year. If your base salary changes during the year and you are bumped into another tier, your premium share will not change for the remainder of the calendar year.

Dental Premiums

Employees pay 20% of the experience-rated premiums. The premium share for dental coverage is set according to the following family structure:

- Employee only
- Employee plus one dependent
- Employee plus two or more dependents

Part-Time Employees

Employees working on a part-time basis (at least 21 to 36 hours per week) pay the applicable premium share for medical coverage based on their pro-rated salary as of January 1 of each year. For example, if you would make $100,000 based on a 40 hour work week, you will pay medical premiums based on salary tier 3. However, if you work 25 hours per week, your salary would be $63,500 and you will pay medical premiums based on salary tier 2. Dental premiums are paid according to the applicable employee premium-share without respect to salary level.

Part-time employees working 20 hours per week will pay one-half of the full premium cost for medical, dental and vision coverage.

Dual Sandians

If you are a Sandia employee married to another Sandia employee or to a Sandia retiree, you are considered a dual Sandian. You, as a dual Sandian, may elect to cover yourself as (1) an individual, or (2) a dependent of your Sandia spouse, or (3) as the primary covered employee or retiree with your Sandia spouse as a dependent. If you, as the employee, are the primary covered member, cost-sharing of monthly premiums will be based on your salary tier.

If you and your Sandia spouse elect to be covered separately, any eligible dependents may be covered under either spouse (e.g., some dependents may be enrolled under one spouse while other dependents are enrolled under the other spouse). Dependents may NOT be covered under both Sandians simultaneously.

> **Note:** Under Sandia's medical, dental, and vision Programs, employees, retirees, or eligible dependents cannot be covered as both a primary covered member and a dependent, or as a dependent of more than one primary covered member.

Employees, retirees, or other qualifying individuals who are covered by any Sandia medical, dental, or vision Program are not eligible to participate in a second Sandia medical, dental, or vision Program (e.g., no double coverage by Sandia health Programs). You have the option to change your Sandia health benefit coverage once a year during the Open Enrollment period Sandia holds each fall.

Class II Premium

Class II dependents enrolled prior to 1987 are included in the premium share you pay for yourself and your Class I dependent(s). Any Class II dependent you enrolled after 1986 and prior to January 1, 2009, or March 1, 2009 for OPEIU-represented employees, are **not** counted as dependents in calculating the family premium, and you will pay a separate Class II premium. This premium is 70% of the experience-rated premium. You may contact Sandia HBE at 505-844-HBES (4237) for premium-share information.

Domestic Partner Premium

Generally, you will pay a monthly premium, as well as imputed income, for enrolled same-gender domestic partners and their eligible dependents you enroll in your medical and dental Programs.

The premium share will vary based upon your salary tier, coverage level, and medical Program selected. For information on specific premium-sharing provisions for domestic partners contact Sandia HBE at 505-844-HBES (4237). The example below illustrates how the premium share would be calculated if you added a same-gender domestic partner to your medical coverage.

Example: The premium-share for an employee plus spouse is $180 per month and for an employee only is $87 per month. The premium-share you would pay to add a same-gender domestic partner would be $93 ($180 minus $87).

Imputed Income Requirement

Benefits paid under a group health plan for your covered dependents who are not a qualifying child or relative under the Internal Revenue Code causes you to receive additional compensation as taxable wages. Generally, same-gender domestic partners and their children do not meet this definition and are, therefore considered Non-Qualifying dependents. You are required to declare as taxable income the value (imputed income) of the coverage for your Non-Qualifying Dependent(s). Imputed income is not a pay increase. It is the value of Sandia's contributions for health plan coverage for dependents who do not meet the criteria as a qualifying child or qualifying relative. The imputed income will be added to your gross income and will be subject to income tax and may be subject to FICA (Social Security and Medicare) and income taxes. This amount will be reported on your annual W-2 from Sandia or other appropriate reporting tax form.

Note: State law requirements may vary. For example, California currently does not tax domestic partner benefits if the domestic partner is registered with the State of California.

Example of Imputed Income: Under the UHC Premier PPO, the monthly full premium for employee only coverage is $405. The monthly full premium for an employee plus one adult is $830. The amount of imputed income in this case is the difference between $830 and $405, or $425 per month. This amount will be added as taxable income to the monthly paycheck and will be taxed as outlined above.

Imputed income will be included in the employee's income UNLESS he/she contacts Sandia Benefits and completes an Affidavit of Tax Status confirming that those dependents discussed above are tax dependents as defined in IRS Publication 502 for health coverage purposes. It is your responsibility to notify the Benefits Department if your covered dependent does not meet the qualifying child or qualifying relative criteria. Should the Internal Revenue Service audit your tax return and determine you have obtained tax benefits for which you are not eligible, you might be responsible for any overdue taxes, interest, and penalties. See Internal Revenue Service (IRS) Publication 502 for help in determining who is a qualifying child or a qualifying relative.

Premiums during a Leave of Absence

Sandia provides various Leaves of Absence Programs for eligible employees. Refer to the applicable Corporate Policy on Leaves of Absence for eligibility information as well as other general information on Leaves of Absence. Refer to Section 10, Continuation of Group Health Coverage for information on continuing your coverage while on a Leave of Absence.

The following table outlines the length of time that you will pay your employee premium share for your medical, dental, and vision coverage for the various leaves of absence as well as what you will pay after the employee premium share time has expired:

If your Leave of Absence began	You will pay the premium amounts below	For each Leave of Absence as noted below					
		Child Care Leave of Absence	**Family Care Leave of Absence**	**Personal Leave of Absence**	**Military Leave of Absence**	**Special Leave of Absence**	**Special Leave of Absence for Tribal Government Appointments**
Prior to March 1, 2009	Employee Premium Share	During the first six months	During the first six months	Not applicable	During the first six months	Not applicable	For the duration of the Leave
	Full Premium(1)	For continued Sandia medical, dental, and vision coverage beyond the time period noted above.					
March 1, 2009 and later	Employee Premium Share	Up to twelve weeks	Up to twelve weeks	Up to twelve weeks	Up to twelve weeks	Up to twelve weeks	Up to twelve weeks
	Full Premium plus 2% administrative fee (also known as COBRA rate)	For continued Sandia medical, dental, and vision coverage beyond the time period noted above. You can continue for up to 36 months. This runs concurrently with COBRA.					

(1) The full premium is the total combined employer and employee paid premium for coverage.

Note: If you do not continue your Sandia medical, dental, and vision coverage during your leave, you will need to reenroll to reinstate your Sandia medical, dental, and vision coverage when you return from leave.

COBRA Premium

Sandia requires persons who elect continuation of the employer-provided health coverage to pay the full cost of the coverage, plus a two percent administrative charge. The required COBRA premium is more expensive than the amount that active employees are required to pay, but may be less expensive than individual medical coverage. COBRA continuation coverage lasts only for a limited period of time. See Section 10, "Continuation of Group Health Coverage" for more information.

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Section 6. General Information

This section provides information on the Program Summary materials, pre-existing condition limitations, general provider network information, and required ERISA notices.

Program Summary Material

The Program Summary materials for the medical, dental, and vision Programs in which you are enrolled generally will be sent to you. If you do not receive this material, contact Sandia's HBE at 505-844-HBES (4237).

For new hire or open enrollment elections, upon enrolling through HR Self-Service, you will receive an electronic notice providing you with a link to the Program Summary materials. If you do not receive your Program Summary materials, you may contact Sandia HBE at 505-844-HBES (4237).

Generally, any new or updated Program Summary materials or other notices are distributed through an electronic notice through the HBE Update providing either the information or a link to where you can find the information.

The Program Summary material listed in Appendix A of this document describes the nature of covered services including, but not limited to:

- Coverage of drugs, emergency care, preventive care, medical tests and procedures, hospitalization and durable medical equipment;
- Eligibility to receive services;
- Exclusions and limitations;
- Cost sharing (including deductibles and copayment amounts);
- Annual and lifetime maximums and other caps or limits;
- Circumstances under which services may be denied, reduced, or forfeited;
- Procedures, including pre-authorization and utilization review, to be followed in obtaining services; and
- Procedures available for the review of denied claims.

Information about your medical, dental and vision Programs is available in Appendix A of this document. You may also obtain a copy of the Program Summary materials for the medical, dental, and vision Program in which you are enrolled by contacting Sandia's HBE at 505-844-HBES (4237).

Pre-existing Conditions Limitations

When you enroll in a Sandia-sponsored medical, dental, or vision Program, you will not be excluded from enrollment based on your health, nor will your premium or level of benefits be based on any pre-existing health conditions. The same applies to your dependents.

Provider Networks

If you are enrolled in a medical, dental or vision Program that offers benefits through provider networks, a list of providers will be provided to you without charge after your coverage takes effect (in the same electronic notice you received upon enrollment).

> **Note:** If you enroll in the Kaiser HMO, Kaiser will mail a provider directory directly to your home upon enrollment, and annually, thereafter. Refer to the Kaiser Evidence of Coverage for more information.

You can also obtain provider directories by contacting the medical, dental, or vision Program directly at the address or phone number listed in Appendix B of this document. You may also contact Sandia HBE at 505-844-HBES (4237). For the most up-to-date listing of providers, it is recommended that you log on to the Claims Administrator's website to find out current in-network providers.

Refer to the Program Summary material in Appendix A for a description of:

- How to use network providers,
- The composition of the network,
- The circumstances under which coverage will be provided for out-of-network services, and
- Any conditions or limits on the selection of primary care providers or specialty medical providers that may apply.

Required ERISA Notices

Maternity Hospital Stays (Newborns' and Mother's Health Protection Act)

Federal law protects the benefit rights of mothers and newborns related to hospital stays in connection with childbirth. In general, group health Programs and health insurance issuers may not:

- Restrict benefits for the length of hospital stay for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does allow the mother's or newborn's attending physician, after consulting with the mother, to discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable).
- Require that a physician obtain authorization from the plan or the insurance issuer for prescribing a length of stay of up to 48 hours following a vaginal delivery (or 96 hours following a Cesarean Section).

For details on any state maternity laws that may apply to your medical Program, please refer to the Program Summary material listed in Appendix A for the medical Program in which you are enrolled.

Benefits for Mastectomy-Related Services (Women's Health and Cancer Rights Act)

The medical Programs sponsored by Sandia will not restrict benefits if you or your dependent:

- Receives benefits for a mastectomy, and
- Elects breast reconstruction in connection with the mastectomy.

Benefits will not be restricted provided that the breast reconstruction is performed in a manner determined in consultation with you or your dependent's physician and may include:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Benefits for breast reconstruction will be subject to annual deductibles and coinsurance amounts consistent with benefits for other covered services under the Program.

Health Insurance Portability and Accountability Act (HIPAA) Special Enrollment Periods

Under the special enrollment provisions of HIPPA, you and your dependents may be eligible, in certain situations, to enroll outside of Open Enrollment in a "group health plan" (as defined by the Health Insurance and Portability and Accountability Act). For purposes of the medical, dental, and vision Programs offered by Sandia, a group health plan does not include "limited-scope dental benefits", therefore, enrollment is limited to the medical and/or vision Programs. Under this Act, "dependent" is defined as any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant.

IMPORTANT: Enrollment requests must be submitted to the Sandia Benefits Department within the applicable time period noted on the next page. Documentation supporting the enrollment request can be submitted separately from the enrollment paperwork but must be submitted within 60 calendar days of the HIPAA SEP event, except for adoption/placement for adoption where it must be provided at the time of enrollment. Refer to Section 4, Mid-Year Enrollment/Disenrollment Events or contact Sandia HBE at 505-844-HBES (4237) for more information. If the enrollment paperwork was submitted within the applicable time frame but no supporting documentation is received within the 60-day period, no enrollment will be done.

1) If you declined enrollment in a Sandia medical or vision Program for yourself or your eligible dependents (including your spouse) because of other group or individual medical or vision

coverage, you may be able to enroll yourself and your eligible dependents in a Sandia medical or vision Program during the year. This special enrollment may be available if, during the year, you or your eligible dependent(s) lost coverage under a non-Sandia-sponsored individual or group medical or vision plan (regardless of whether the person who lost coverage is eligible for or elected COBRA continuation coverage). For this purpose, a loss of coverage may include:

- Coverage ended due to loss of eligibility;
- Employer contributions to the plan stopped;
- The plan was terminated;
- COBRA coverage was exhausted; or
- The lifetime maximum for medical benefits was exceeded under medical or vision plan.

You must request special enrollment in a Sandia medical or vision Program within 31 calendar days of the loss of coverage, otherwise, you will need to wait until the open enrollment period. Coverage will be effective as of the date of loss of coverage or upon receipt of enrollment paperwork, whichever is later.

2) If you gain a new dependent during the year as a result of marriage, birth, adoption or placement for adoption, you may enroll that dependent, as well as yourself and any other eligible dependents, in the medical or vision Program.

You must request special enrollment in a Sandia medical or vision Program within 31 calendar days of the event, otherwise, you will need to wait until the open enrollment period. If the event is birth, adoption, or placement for adoption, coverage will be retroactive to the date of the event. You can also submit enrollment paperwork after the 31st calendar day but before the 61st calendar day of the event for a birth, an adoption, a placement for adoption, however, the coverage effective date will not be retroactive. If the event is marriage, coverage will be effective as of the date of the event or upon receipt of enrollment paperwork, whichever is later.

3) Effective April 1, 2009, if you or your eligible dependent is eligible for Sandia medical or vision coverage, but not enrolled, you may request enrollment before the next annual open enrollment period under the following circumstances:

- You and/or your dependent(s) become eligible for a premium assistance subsidy under Medicaid or the Children's Health Insurance Program (CHIP) with respect to coverage under a Sandia medical or vision Program, if you request coverage under a Sandia medical or vision Program no later than 60 days after the date you or your dependent(s) is determined to be eligible for such assistance.
- Coverage under Medicaid or CHIP for you and/or your dependent(s) is terminated as a result of loss of eligibility for such coverage, and you request coverage under a Sandia medical or vision Program no later than 60 days after the date of termination of such coverage.

Note: Special enrollment rights allow you to either enroll in your current medical Program or enroll in any medical Program for which you and your dependents are eligible.

Section 7. Coordination of Benefits (COB)

This section defines and explains the provisions designed to eliminate duplicate payments and to provide the sequence in which coverage will apply (primary and secondary) when a person is covered under a Sandia medical, dental, and vision Program by the same type of coverage provided by another group health plan. Refer to the Coordination of Benefits Section for each Program Summary to find out the specific requirements, if any, for that Program.

Note: If you are enrolled in the Kaiser HMO, you will need to refer to the Kaiser Program Summary (also known as the Evidence of Coverage) for information on the COB provisions for that Program.

Policy

All benefits for which you enroll under the Sandia medical, dental, and vision Programs are subject to coordination with the benefits of other health coverage under other group health plans including Medicare, if medical expenses are considered covered expenses under the Sandia medical, dental, and vision Programs. Covered expense for this section means any expense that is eligible for reimbursement by a Sandia medical, dental or vision Program during a claim period. Any covered expense that is not payable by the primary non-Sandia-sponsored health plan because of the covered member's failure to comply with cost containment requirements (e.g., second surgical opinions, pre-admission testing, pre-admission review of hospital confinement, mandatory outpatient surgery, etc.) will not be considered a covered expense and, therefore, will not be eligible for reimbursement under the Sandia medical, dental, or vision Program.

Notes: The Sandia Dental Care Program contains a non-duplication of benefits provision. Refer to the Coordination of Benefits section in the Dental Care Program for more information on how that Program coordinates benefits.

If your covered dependent has primary prescription drug coverage through a non-Sandia-sponsored medical plan, including Medicare, your covered dependent is not eligible to use the mail order service through your medical Program. In addition, your covered dependent will only have secondary coverage under the retail pharmacy benefit. Refer to your medical Program Summary for more information. This provision does not apply to the Kaiser HMO.

If your other health plan, including Medicare, does not cover a health service that is covered under the Sandia medical, dental, or vision Program, then the Sandia medical, dental, or vision Program will pay as primary for the covered health service.

Rules for Determining Which Plan Provides Primary Coverage and Other Details of the Benefit Payment

The Coordination of Benefits (COB) applies only to group health plans and not to individual insurance, and does not apply when married persons are both members in Sandia's medical, dental, or vision Programs.

If you or your covered dependents are also covered under another medical, dental, or vision Program, use the table below to determine which Program pays for primary coverage and which Program pays for secondary coverage.

If…	Then…
The other Program (including HMOs) does not have a COB provision	The Program with no COB provision is primary
Both Programs have COB provisions	The Program covering the person as an employee is primary and pays benefits up to the limits of that Program. The Program covering the person as a dependent is secondary and pays the remaining costs to the extent of coverage
Both Programs have COB provisions and use the birthday rule for dependent children coverage	The Program covering the parent whose birthday comes first (month and day) in the year is the primary Program and pays benefits first. The Program covering the other parent is secondary and pays the remaining costs to the extent of coverage
Both Programs have COB but neither Program uses the birthday rule for dependent children's coverage	The male-female rule applies. The rule says that the father's group insurance is the primary Program and pays benefits first. The mother's group insurance is secondary and pays the remaining costs to the extent of her coverage
Both Programs have COB but one parent is covered by the male-female rule and the other by the birthday rule	The male-female rule applies. The rule says that the father's group insurance is the primary Program and pays benefits first. The mother's group insurance is secondary and pays the remaining costs to the extent of her coverage
A divorce or legal decree establishes financial responsibility for health care for the covered dependent children	The parent who has the responsibility is the holder of the primary Program
A divorce decree does not establish financial responsibility for health care of the dependent	The Program of the parent with custody is the primary Program; the other parent's Program is secondary
A divorce decree does not establish financial responsibility and assigns joint custody	Each parent is primary when the child is living in that parent's home
A divorce decree does not establish financial responsibility, and the parent with custody remarries	The custodial parent's Program remains primary; the stepparent's Program is secondary; the noncustodial parent's Program is third
Payment responsibilities are still undetermined	The Program that has covered the patient for the longest time is the primary Program

Coordination of Benefits with Medicare

Sandia interfaces with Medicare to eliminate duplicate payments and to provide sequence in which coverage applies. Generally, Medicare provides primary coverage for those not covered by a Sandia medical benefit Program by reason of current employment status. See Section 3, "Eligibility Information" for more information.

Note: For members with Medicare, refer to the booklet entitled "Sandia Health Benefits Plan for Retirees Summary Plan Description" for more information.

Injuries or Illnesses Alleged to be Caused by a Third Party

IMPORTANT: If you are enrolled in the Kaiser HMO, you will need to refer to the Kaiser Program Summary (also known as the Evidence of Coverage) for information on this provision.

When you or your covered dependent are injured or become ill because of the actions or inactions of a third party, the Sandia Health Benefits Plan for Employees may cover your eligible health care (medical, prescription drug, dental and vision) expenses. However, to receive coverage, you must notify the Sandia Health Benefits Plan for Employees that your illness or injury was caused by a third party, and you must follow special Sandia Health Benefits Plan for Employees rules. This section describes the Sandia Health Benefits Plan for Employees' procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else's fault, the Sandia Health Benefits Plan for Employees has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Sandia Health Benefits Plan for Employees has the right to recover such expenses directly out of any payment made to you by the at-fault party or any other party related to the illness or injury.

By accepting Sandia Health Benefits Plan for Employees benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Sandia Health Benefits Plan for Employees:

- Has an equitable lien on any and all monies paid, or payable to you, or for your benefit by any responsible party or other recovery to the extent the Sandia Health Benefits Plan for Employees paid benefits for such sickness or injury;
- May appoint you as constructive trustee for any and all monies paid, or payable to you, for your benefit by any responsible party or other recovery to the extent the Sandia Health Benefits Plan for Employees paid benefits for such sickness or injury; and

- May bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the sickness or injury.

If you, your attorney, or other representative receive any payment from the sources listed later in this section – through a judgment, settlement or otherwise – when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the Sandia Health Benefits Plan for Employees has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Sandia Health Benefits Plan for Employees has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Sandia Health Benefits Plan for Employees back first, in full, out of such funds for any health care expenses the Sandia Health Benefits Plan for Employees has paid related to such illness or injury. You must pay the Sandia Health Benefits Plan for Employees back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses.

The "make whole" doctrine does not apply and does not limit the Sandia Health Benefits Plan for Employees's right to recover amounts it has paid on your behalf. Furthermore, you must pay the Sandia Health Benefits Plan for Employees back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it.

Additionally, the Sandia Health Benefits Plan for Employees is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds.

The Sandia Health Benefits Plan for Employees's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representative(s) receive or are entitled to receive;
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representative(s) receive;
- Any equitable lien on the portion of the total recovery which is due the Sandia Health Benefits Plan for Employees for benefits it paid; and
- Any liability or other insurance (for example, uninsured motorist, under insured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representative(s)

As a Sandia Health Benefits Plan for Employees participant, you are required to:

- Cooperate with the Sandia Health Benefits Plan for Employees' efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Sandia Health Benefits Plan for Employees' subrogation or recovery rights outlined in this Summary.

- Notify the Sandia Health Benefits Plan for Employees within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- Provide all information requested by the Sandia Health Benefits Plan for Employees, the Claims Administrator or their representatives, or the Sandia Health Benefits Plan for Employees Administrator or its representatives.
- Execute and deliver such documents as may be required and do whatever else is needed to secure the Sandia Health Benefits Plan for Employees rights.

The Sandia Health Benefits Plan for Employees may terminate your participation and/or offset your future benefits for the value of benefits advanced in the event that the Sandia Health Benefits Plan for Employees does not recover, if you do not provide the information, authorizations, or otherwise cooperate in a manner that the Sandia Health Benefits Plan for Employees considers necessary to exercise its rights or privileges under the Sandia Health Benefits Plan for Employees.

If these subrogation provisions conflict with subrogation provisions in an insurance contract governing benefits at issue, the subrogation provisions in the insurance contracts will govern. If these right of recovery provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the right of recovery provisions in the insurance contract will govern.

All Sandia Health Benefits Plan for Employees rights under this section remain enforceable against the heirs and estate of any covered person.

Failure to comply with the health's subrogation and recovery rules may result in termination of coverage for cause as well as legal action by the health plan to recover benefits paid that would otherwise have been subject to subrogation or recovery under these provisions.

Note: If the injured party is a minor dependent, the primary subscriber must comply with the above agreement and/or duties.

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Section 8. Claims and Appeals Procedures

This section provides general information regarding claims and appeals procedures applicable to the medical, dental, and vision Programs.

IMPORTANT: For specific claims and appeals procedures for a claim for benefits, refer to the applicable Program Summary in Appendix A of this document.

In performing their obligation to process and adjudicate claims for plan benefits, the claims administrators listed in Appendix B act as fiduciaries, as defined by and in compliance with applicable provisions of ERISA. Sandia accordingly delegates to the claims administrator the discretionary authority necessary to fulfill this role. As the claims fiduciary, the claims administrator has the sole authority and discretion to determine whether submitted services/costs are eligible for benefits and to interpret, construe, and apply the provisions of their respective Program (with the exception of a claim that is applicable only to member eligibility provisions which, except for incapacitated dependent status, are determined by Sandia) in processing and adjudicating claims.

IMPORTANT: All claims must be submitted within one year after the date of service in order to be eligible for consideration of payment or as provided in the applicable insurance policy. The one-year requirement will not apply if you are legally incapacitated. If your claim relates to a hospital stay, the date of service is the date your hospital stay ends.

Upon written request and free of charge, a participant may examine documents relevant to his/her claim and submit opinions and comments. The claims procedures for each specific Program will be furnished to you without charge. If you do not receive the claims procedures, please contact the Sandia HBE at 505-844-HBES (4237) or e-mail https://hbe.sandia.gov.

Benefits Payment

Refer to the applicable medical, dental, or vision Program for specific information on benefits payments. In general, if the service is rendered in-network, payment will be made directly to the provider. If the service is rendered out-of-network, payment will be made directly to the employee.

Note: The person who received the services is ultimately responsible for payment of services received from the providers.

If any benefits of your medical, dental or vision Program are payable to the estate of a covered member or to a minor or individual who is incompetent to give valid release, the Claims Administrator may pay such benefits to any relative or other person whom the Claims Administrator determines to have accepted competent responsibility for said minor or individual who is incompetent and who is able to give a valid release or as otherwise required by law. Any payment made by the medical, dental or vision Program in good faith pursuant to the provision shall fully discharge the medical, dental, or vision Program and Sandia to the extent of such payment.

Members cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the Sandia medical, dental, or vision Programs before receipt of that benefit. Your interest in your medical, dental, or vision Program is not subject to the claims of creditors. Exceptions include:

- A QMCSO that requires a health plan to provide benefits to the employee's child
- Subject to the written direction of an employee, all or a portion of benefits provided by the Sandia medical, dental, or vision Program may, at the option of the Claims Administrator and unless the individual requests otherwise in writing, be paid directly to the person rendering such service. Any payment made by the Sandia medical, dental, or vision Program in good faith pursuant to this provision shall fully discharge the Sandia medical, dental, or vision Program and Sandia to the extent of such payment.

On occasion, there are outstanding benefit payment checks that have been paid by a Claims Administrator but have not been cashed and have been stale-dated. In this case, the primary covered member must notify the claims administrator or the Sandia Benefits Department within two calendar years from the end of the Plan year in which the service was rendered to claim funds; otherwise the monies will be forfeited.

Filing an Initial Claim

You must follow the claims procedures established by the medical, dental, or vision Programs. If you need a claim form, you may call your Claims Administrator (phone number on back of member ID card) or log on to your Claims Administrator's website to obtain a claim form. See Appendix B of this document for website information. You may also obtain a claim form from Sandia Corporate Forms or from Sandia Benefits at 505-844-HBES (4237).

Note: Presentation of a prescription to a pharmacy is not in and of itself considered an initial claim.

Timeframes for Initial Claims Decisions

Separate schedules apply to the timing of claims, depending on the type of claim. There are four types of claims:

- **Urgent Care** – a claim for health care or treatment that has to be decided more quickly because the normal timeframes for decision-making could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician with knowledge of your condition, subject you to severe pain that cannot be adequately managed without the care or treatment addressed in the claim. Does not apply to dental or vision Programs.
- **Pre-service** – a claim for a health benefit – other than an urgent care claim – that must be approved in advance of receiving medical care (for example, requests for pre-certifying a hospital stay or for pre-approval under a utilization review program). Does not apply to dental or vision Programs. Pre-determination of benefits is available under the Dental Care Program but is not required to receive benefits. Refer to the Dental Care Program for more information.
- **Concurrent care** – a claim for a health benefit which the medical Program – after having previously approved an ongoing course of medical treatment provided over a period of time or a specific number of treatments – subsequently reduces or terminates coverage for the treatments (other than by Program amendment or termination). Does not apply to dental or vision Programs.
- **Post-service** – any other type of claim for a health benefit

The following table outlines the general deadlines for the initial determination, identifies whether any extensions are available, and the deadlines if additional information is needed:

	Urgent Care Claims	Pre-Service Claims	Post-Service Claims	Concurrent Care Claims
What is the general deadline for initial determination?	No later than 72 hours from receipt of claim	15 calendar days from receipt of the claim	30 calendar days from receipt of the claim	Must be provided sufficiently in advance to give claimant an opportunity to appeal and obtain a decision before the benefit is reduced or terminated. A request to extend a course of treatment will receive a response within 24 hours, if the claim is made at least 24 hours prior to the expiration of the period of time or number of treatments. **Note:** if the claim is not made at least 24 hours prior to the expiration of the period of time or number of treatments, then the claim reverts to either an urgent care claim, pre-service or post-service claim.
Are there any extensions?	No, but see below for extensions based on insufficient information	Yes. One 15 calendar day extension, if the claims administrator determines it is necessary due	Yes. One 15 calendar day extension, if the claims administrator determines it is necessary due to	No

	Urgent Care Claims	Pre-Service Claims	Post-Service Claims	Concurrent Care Claims
		to matters beyond its control and informs the claimant of the extension within this time frame	matters beyond its control and informs the claimant of the extension within this time frame.	
What is the deadline if additional information is needed?	Claimant must be notified of the need for additional information within 24 hours of receipt of the claim. Claimant must be given at least 48 hours to respond. The running of time is suspended for 48 hours or until the information is received, whichever is earlier.	If an extension is necessary because claimant failed to provide necessary information, the notice of extension must specify the information needed. Claimant must be given at least 45 calendar days to respond. The running of time for the initial claims determination is stopped until the end of the prescribed response period or until information is received, whichever is earlier. At that point the decision will be made within 15 calendar days.	If an extension is necessary because claimant failed to provide necessary information, the notice of extension must specify the information needed. Claimant must be given at least 45 calendar days to respond. The running of time for the initial claims determination is stopped until the end of the prescribed response period or until information is received, whichever is earlier. At that point the decision will be made within 15 calendar days.	Not applicable

Contents of Notice and Response from the Claims Administrator

After your claim is reviewed by the Claims Administrator, you will receive a notice of benefit determination within the timeframes specified above. For Urgent Care and Pre-Service claims, you will receive a notice of benefit determination whether or not the Claims Administrator makes an adverse decision on your claim. For Post-Service and Concurrent Care Claims, you are entitled to receive a notice of benefit determination if the Claims Administrator makes an

adverse decision on your claim. The notice of benefit determination will include all of the following:

- Specific reasons for the denial;
- References to the specific plan provisions upon which the denial is based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why that material or information is necessary;
- Description of the plan's appeal procedure, its deadlines, including, if applicable, the expedited review available for urgent claims, and the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse decision on appeal;
- If applicable, a copy of any rule, guideline, or protocol relied upon in making the adverse determination, or a statement that the rule or guideline was relied upon and will be provided, upon request, free of charge;
- If an adverse determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse determination (or a statement that such explanation will be provided) free of charge upon request.

Filing an Appeal

IMPORTANT: Upon denial of a claim, you have 180 calendar days of receipt of the notification of adverse benefit determination to appeal the claim.

If a claim for benefits is denied in part or in whole, you have the right to appeal the claim. A request for further information (such as a diagnosis) from the provider of service is not a claim denial. The medical Programs also have a Voluntary External Review Program as described in each medical Program Summary. You must exhaust the mandatory levels of appeals process before you can request an external review or seek other legal recourse.

IMPORTANT: Regardless of the decision and/or recommendation of the Claims Administrator, Sandia Corporation, or what the Program will pay, it is always up to the member and the doctor to decide what, if any, care he or she receives.

The table below outlines who to contact based on the reason for the claim denial:

If you have a claim denied because of…	Then…
Eligibility (except for incapacitation determinations)	See Eligibility Appeals Procedure
Eligibility based on incapacitation determinations	Contact the medical or dental claims administrator, whichever is applicable. For the Vision Care Program, contact the Sandia Benefits Department for assistance
Benefit Determinations	See the applicable Program Summary for the appeals procedures Refer to the Kaiser HMO Program Summary (also known as the Evidence of Coverage) for specific information on appeal procedures for Kaiser participants Refer to the Eligibility Appeal Procedures if you have a claim denied by a claim administrator based solely on eligibility

Timeframes for Appeals Decisions

The table below outlines general appeal deadlines by which a claimant must be notified of an appeals decision as well as the mandatory level of reviews for each claim (see the specific Program summary for the appeal procedures):

	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Appeal deadline by which a claimant will be notified of appeals decision	As soon as possible taking into account medical exigencies, but no more than 72 hours **Note:** You do not need to submit the claim appeal in writing. Call the Claims Administrator as soon as possible to appeal a claim.	For the first level of appeal, 15 calendar days from receipt of appeal For the second level of appeal, 15 calendar days from receipt of the appeal for each level **Note:** Pre-Service Claims are not applicable under the Dental Care Program but a non-ERISA appeals process does apply to Pre-determination of Benefits. Refer to the Dental Care Program Summary.	For the first level of appeal, 30 calendar days from receipt of appeal For the second level of appeal, 30 calendar days from receipt of the appeal for each level

Note: An appeal of a concurrent care claim decision to reduce or terminate previously approved benefits may be an urgent care, pre-service or post-service claim depending on the facts.

Your Right to Information

If the appeal is denied, the notification will:

- Explain the specific reasons and specific Plan provisions on which the decision is based;
- Include a statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain information about these procedures;
- Include a statement regarding the Claimant's right to bring a civil action under ERISA 502(a); and
- Offer to provide the Claimant, on request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

You are also entitled to access and copy any internal rule, guideline, protocol, or other similar criteria used as a basis for a decision on your denied claim or appeal upon request, free of charge. Similarly, if your claim or appeal is denied based on a determination involving a medical, dental, or vision care judgment, you are entitled to an explanation of the scientific or clinical reasons for that determination, free of charge upon request.

Eligibility Appeal Procedures

You may use the eligibility appeals procedure to request an informal review, a formal review, or both, if:

- You or your dependent(s) had a benefit claim that was denied by a claims administrator based solely on eligibility, or
- You or your dependent(s) have been informed by the Benefits Department that either you or your dependent(s) are not eligible for participation in the Sandia Health Benefits Plan for Employees (e.g., your dependent is denied eligibility to participate in your medical Program or you missed the enrollment window).

IMPORTANT: The deadline for submitting a request for an informal or formal review of your eligibility to the Benefits Department will be 180 days after you receive written notification of the denial of the claim by the claims administrator or denied participation by Sandia Benefits to enroll in a medical, dental, and/or vision Program. Once final resolution has been reached on your eligibility appeal by Sandia, you then have 180 days (from the date of the written notification by Sandia) to appeal your denied claim for benefits with the claim administrator.

Request for Informal Review

You have the option to request an informal review of your appeal for eligibility by contacting Sandia HBE at 505-844-HBES (4237). The Sandia Benefits Department will review all pertinent information and render a written decision as soon as possible but no later than fourteen (14) calendar days of the receipt of all material facts. If you are not satisfied with the decision of the Sandia Benefits Department, you can request a formal review.

Request for Formal Review

To request a formal review of a denial based solely on eligibility, you must submit an appeal in writing to the Secretary of the Employee Benefits Committee, c/o Benefits Department, PO Box 5800, Albuquerque, NM 87185, MS 1463. If the denied claim is based on any reason other than eligibility, you must file the appeal with the appropriate claims administrator listed in Appendix B. You will receive a response to your appeal based on the following time frame:

- If an urgent care claim, within 72 hours of receipt of the appeal
- If a pre-service claim, within 30 calendar days of receipt of the appeal
- If a post-service claim, within 60 calendar days of receipt of the appeal

If the appeal related solely to eligibility is denied, the notification will:

- Explain the specific reasons and specific Plan provisions on which the decision is based;
- Include a statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain information about these procedures;
- Include a statement regarding the Claimant's right to bring a civil action under ERISA 502(a); and
- Offer to provide the Claimant, on request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your eligibility claim.

A claim or appeal regarding eligibility may be filed by an authorized representative on behalf of a Claimant. The decision by the Employee Benefits Committee will be the final and conclusive administrative review proceeding under the Sandia Health Benefits Plan for Employees. The Claimant is required to pursue all administrative appeals described above as a precondition to challenging the denial of the claim in a lawsuit.

Note: The Claimant may not submit a dispute regarding eligibility to a court with respect to a denied claim under the Sandia Health Benefits Plan for Employees more than one hundred eighty (180) days after the date the Employee Benefits Claim Review Committee renders its final decision upon appeal.

Sandia Health Benefits Plan for Employees dependent eligibility based on incapacitation is determined by the applicable medical and/or dental Claims Administrator. Contact Sandia HBE at 505-844-HBES (4237) for information on applying for dependent incapacitation status.

Recovery of Excess Payment

The Claims Administrator has the right at any time to recover any amount paid by a Sandia medical, dental or vision Program for covered charges in excess of the covered benefits under the medical, dental, or vision Program provisions. Payments may be recovered from covered members, providers of service, and other medical care plans.

IMPORTANT: By accepting benefits under the Sandia Health Benefits Plan for Employees, the covered member agrees to reimburse payments made in error and cooperate in the recovery of excess payments.

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Section 9. When Coverage Ends

This section outlines when coverage ends for employees, Class I, and Class II dependents. See Section 10, "Continuation of Group Health Coverage" for specific rules governing how health coverage may be continued for the above referenced groups.

Active Employees

Medical, dental, and vision benefits for active employees end on the:

- Last day of the month that the employee's leave of absence or termination of employment becomes effective, except as provided under temporary continuation of coverage under COBRA or otherwise provided by law or by the provisions of this Summary Plan Description. If you terminate employment due to retirement or disability (and are approved for long term disability benefits through Sandia), refer to the booklet entitled "Sandia Health Benefits Plan for Retirees Summary Plan Description".
- Date the medical, dental, and/or vision benefits are terminated.
- Last day of the month in which any cost of the coverage is not paid when due (if applicable).
- Date of death.
- Submission of a fraudulent claim.
- Termination for cause (see page 9-2)

IMPORTANT: Health care coverage may be continued in some situations. See Section 10, "Continuation of Group Health Coverage," for COBRA rules. Also, special rules apply to leaves of absence for family and medical care (see the Family and Medical Leave Act of 1993) and for military service (Uniformed Services Employment and Reemployment Rights Act of 1994).

Class I and Class II Dependents

Medical, dental, and/or vision benefits for dependents end on the:

- Last day of the month in which the dependent becomes eligible for coverage as an employee under any Sandia health benefit Program.
- Last day of the month that any cost of coverage for dependents is not paid when due.
- Date employee's coverage ends.

- Last day of the month in which the dependent becomes ineligible for coverage under the applicable health benefits Program (refer to Section 3, "Eligibility Information– Events Causing Your Dependent to Become Ineligible).
- Last day of the month in which the employee terminates (disenrolls) dependent coverage.
- Date of death.
- Submission of a fraudulent claim.
- Termination for cause (see page 9-2)

Note: You must disenroll your dependents within 31 calendar days of the date your dependent becomes ineligible for coverage under the applicable Sandia medical, dental, or vision Program.

Refer to Section 10, "Continuation of Group Health Coverage" to determine whether your dependent may be eligible for temporary continued coverage under COBRA

Termination for Cause

Sandia may terminate a member's coverage for cause, upon 30 days written notice, or with written notice effective immediately for gross misconduct. Cause for termination of a member may include any of the following:

- Permitting an unauthorized person to use your medical, dental, or vision identification card (unless you notified the Claims Administrator to report that your card was lost or stolen).
- Abuse of medical, dental, or vision coverage by providing false information on applications or forms.
- Verbal or physical threats to the Claims Administrator's employees, physician, or network provider.
- Fraudulent receipt of medical, dental, or vision services under the applicable Sandia medical, dental, or vision Program for noncovered persons.
- Failure to comply with subrogation and reimbursement rules.

Kaiser may terminate a member's coverage for cause, immediately by sending written notice to the member. Termination will be effective on the date Kaiser sent the notice. Refer to the Kaiser Traditional HMO Evidence of Coverage for definitions on what constitutes cause. You can obtain a copy of the Evidence of Coverage at www.sandia.gov or by calling Sandia HBE at 505-844-HBES (4237).

Certificate of Group Health Plan Coverage

When the Claims Administrator or Kaiser learns of your loss of medical coverage, or the loss of coverage for your dependents, you will receive a Certificate of Group Health Plan Coverage from the Claims Administrator or Kaiser (if enrolled in the Kaiser HMO). This certificate provides proof of your prior health care coverage for the past 18 months or less of coverage.

You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the six-month period before your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy an insurance policy (for yourself or your family member) that excludes coverage for medical conditions that are present before you enroll.

You have the right to request (for up to two years following the event that caused the loss of coverage) a Certificate of Group Health Plan Coverage by contacting the Claims Administrator or Kaiser (if enrolled in the Kaiser HMO).

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Section 10. Continuation of Group Health Coverage

This section outlines coverage options during a leave of absence, as well as the continuation of group health care coverage under COBRA in the event where you lose coverage under certain circumstances. For information on continuing coverage under the health benefit Programs in the event you become a Long Term Disability Terminee, a Surviving Spouse and/or Surviving Dependents, or a retiree, refer to the booklet entitled "Sandia Health Benefits Plan for Retirees Summary Plan Description."

Coverage During Leaves of Absence

Leaves of Absence

If you take an approved leave of absence, you are eligible to continue the same medical, dental and vision Programs you had as an active employee. Refer to Section 5, "Program Premiums" for information on the premiums for continued coverage under a Sandia medical, dental or vision Program while you are on a leave of absence. You will receive paperwork to continue your coverage. If you wish to continue coverage under the applicable Sandia medical, dental or vision Program, you will be responsible for paying your monthly premiums on an after-tax basis. You are eligible to continue your coverage for a total of thirty-six (36) months from your first day of leave, which includes the portion you pay at the employee premium-share and the full premium plus the 2% administrative fee. If you do not continue to pay premiums during your Leave of Absence, your coverage will be canceled. Contact Sandia HBE at 505-844-HBES (4237) for any questions you may have.

IMPORTANT: Coverage during the leave of absence runs concurrently with (e.g., applies toward) the temporary continued coverage under COBRA (with the exception of leave under the Family and Medical Leave Act). If you terminate employment at the end of the leave, additional coverage months may be available under COBRA depending on the number of months taken for the leave. You will receive a COBRA notice and an election offer at the time your leave begins (as described under COBRA later in this section) and you will need to submit that election in order to take advantage of continued coverage during a leave.

If you return from a leave of absence, you must enroll yourself, as well as any eligible Class I dependents, using Sandia's internal web through HR Self-Service/Benefits/Benefits Enrollment within 30 calendar days of returning to work from the leave of absence. If you do not reenroll in a Sandia medical, dental, or vision Program within 30 calendar days of your date of return from

leave of absence, you cannot reinstate your Sandia coverage until the following Open Enrollment period Sandia holds each fall.

FMLA Absence

If you take any time off under an approved FMLA absence and you do not cancel coverage, coverage will be continued and you will continue to pay your employee premium-share for medical, dental and vision coverage. If any of that time is unpaid, your employee premium-share amounts will be made up upon your return from the unpaid absence. You have the option to cancel your coverage under the applicable Sandia medical, dental, or vision Program you are enrolled in. Written notification to cancel coverage must be received by the Sandia Benefits Department, Attn: HBE, Mail Stop 1463, in writing, within 31 calendar days of the first day of the FMLA absence. If you choose to cancel coverage, coverage will cease at the end of the month in which the Sandia Benefits Department receives written notification.

IMPORTANT: If you have exhausted your FMLA absence and you terminate from Sandia, your COBRA coverage starts upon termination. Refer to COBRA section.

Coverage through COBRA

On April 7, 1986, Congress passed a new law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) at group rates in certain instances where coverage under your medical, dental, and/or vision Program would otherwise end.

IMPORTANT: If you waived health coverage for yourself and your dependents while still employed with Sandia, and you then terminate employment with Sandia without health coverage, you and your dependents are not eligible for any COBRA continuation.

COBRA continuation coverage is a continuation of health coverage when coverage would otherwise end because of a life event known as a qualifying event. See “Qualifying Events Causing Loss of Coverage” in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. A qualified beneficiary includes:

- You,
- Your spouse,
- Your dependent child,
- A dependent child who is enrolled pursuant to a qualified medical child support order (QMCSO),
- An eligible dependent child who is born to or placed for adoption with you during a period of COBRA continuation coverage.

Although domestic partners, children of domestic partners, and Class II dependents, cannot be qualified beneficiaries within the meaning of federal law, Sandia currently offers COBRA-like continuation coverage to these individuals if they were covered under the medical, dental, or vision Programs when group coverage otherwise would have been lost. In this description of COBRA, the term spouse generally includes a domestic partner, the term dependent child generally includes the dependent child of a domestic partner and any other class II dependent, and the term divorce generally includes the termination of a domestic partnership, and COBRA continuation coverage generally includes COBRA-like continuation coverage for domestic partners, children of domestic partners, and Class II dependents.

COBRA qualified beneficiaries may temporarily continue coverage through Sandia by notifying Sandia of a qualifying event (divorce, legal separation, annulment, dissolution of domestic partnership, loss of dependent status). COBRA coverage will continue for qualified beneficiaries who pay the applicable COBRA rate, plus a two percent administrative fee, in a timely manner. If COBRA continuation coverage is not elected, all coverage under the Sandia Health Benefits Plan for Employees will end.

As a qualified beneficiary, Sandia is required to provide coverage which is identical to the coverage provided under the medical, dental, and vision Programs to similarly situated active employees. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect coverage on behalf of their children. Any changes made to the Sandia Health Benefits Plan for Employee's terms that apply to similarly situated active employees will also apply to qualified beneficiaries receiving COBRA continuation coverage.

Effective February 17, 2009, President Obama signed into law the American Recovery and Reinvestment Act of 2009 (ARRA). This law temporarily reduces the premium for COBRA coverage for eligible individuals. Eligible individuals are former Sandia employees (and their dependents who are qualified beneficiaries) who are eligible for COBRA coverage because of involuntary termination from employment at Sandia that occurred from September 1, 2008 through December 31, 2009. Upon election of COBRA, a former employee may be eligible to pay a reduced premium. Eligible individuals pay only 35% of the full COBRA premiums for their Programs for up to 9 months.

Qualifying Events Causing Loss of Coverage

The following table describes how an individual may become a qualified beneficiary due to the event(s) causing loss of coverage, thus making those individuals eligible for continued coverage through Sandia and the maximum period of continuation coverage that is available under COBRA.

Qualified beneficiary if you are the…	And if you, a covered member, lose medical, dental, or vision coverage due to…	Maximum period of continuation coverage is…
Employee Spouse Children	Termination of employee's employment for any reason other than gross misconduct	18 months **Note:** If you are enrolled in the Kaiser HMO when your coverage ends you may be eligible to continue COBRA coverage for a longer period of time directly through Kaiser under Cal-COBRA. Refer to Special COBRA Rights for Kaiser Members.
Employee Spouse Children	Termination of employment (for any reason other than gross misconduct), and you are disabled or become disabled within the first 60 days of your COBRA coverage, as determined by Social Security and you do not have Medicare coverage.	29 months from the original COBRA qualifying event (after the first 18 months you will be charged 150% of the cost of the applicable group rate for self-insured Programs (102% for the Kaiser HMO)).
Spouse Children	Divorce or legal separation of the spouse from the covered employee Death of the covered employee	36 months
Children	Loss of dependent status as referenced in Section 3, Eligibility	36 months
See Disability Extension and Multiple Qualifying Events below for more information.		

Notification of Election of COBRA

The following table shows notification and election actions for temporary continued coverage under COBRA.

Step	Who	Action
1	Employee or family member	Notify Sandia Benefits, in writing, within 60 days after the date on which the following occurs: • Divorce • Legal separation • Annulment

Step	Who	Action
		• Loss of a child's dependent status • Disability designation by Social Security Send notice to: **Sandia National Laboratories** **Attention: Benefits Department, Mail Stop 1463** **P. O. 5800** **Albuquerque, NM 87185** In addition, you must provide documentation supporting the occurrence of the qualifying event, if Sandia requests it. Acceptable documentation includes a copy of the divorce decree or dependent child(ren)'s birth certificate(s), driver's license, marriage license or letter from a university or institution indicating a change in student status. If the above procedures are not followed or if the notice is not provided to Sandia within the 60-day notice period, you will lose your right to elect COBRA. In addition, if any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the qualifying event, you will be required to reimburse the Plan for any claims mistakenly paid.
2	COBRA Administrator	• COBRA Administrator will send you the notice of opportunity to elect temporary continued coverage. If the qualified beneficiary does not receive this notice, the qualified beneficiary should contact Sandia's HBE at 505-844-HBES (4237).
3	Qualified beneficiary	• Qualified beneficiary has 60 days from the later of the date you are furnished the COBRA eligibility notice or the date you would lose coverage. • If you return your election form waiving your rights to COBRA and change your mind within the 60-day election period, you may revoke your waiver and still elect the COBRA coverage as long as it is within the original 60-day election period. However, your COBRA coverage will be effective as of the date you revoked your waiver of coverage. • Qualified beneficiary must make initial premium payment within 45 days from the COBRA election date. You are allowed a 30-day grace period for monthly premium payment thereafter. • If you elect to continue, Sandia provides coverage under the applicable medical, dental or vision Program, at your expense, plus the applicable administrative fee. • If you do not elect to continue coverage during the 60-day election period, coverage through Sandia ends at the end of the month in which the event occurred and the qualified beneficiary became ineligible for coverage. Your election must be postmarked within the 60-day election period. If you do not submit a completed election form within the 60-day election period, you will lose your right to COBRA. • Failure to make any payment within the payment date requirement described above will cause you to lose all COBRA rights. • Following the initial payment, if you do not pay a premium by the first day of a period of coverage, the COBRA Administrator has the option to cancel your coverage until payment is received and then reinstate the coverage retroactively back to the beginning of the period of coverage. Retroactive reinstatement is not available unless payment is received within 30 calendar days of the due date.

Step	Who	Action
		• If the amount of payment is wrong, but is not significantly less than the amount due, the COBRA Administrator will notify you of the deficiency and grant a period of no longer than 30 days to pay the difference. The COBRA Administrator is not obligated to send monthly premium notices.

Each qualified beneficiary has an independent election right for COBRA coverage. For example, even if the employee does not elect COBRA coverage, other family members who are qualified beneficiaries may elect to be covered under COBRA. Also, if there is a choice among types of coverage (for example, medical, vision, dental), each qualified beneficiary who is eligible for COBRA continuation coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child may elect different coverage (medical, dental or vision) than the employee elects.

A covered employee or spouse can also make the COBRA election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA coverage.

Termination of COBRA

Early termination of continuation coverage may occur for any of the following reasons:

- Premiums are not paid in full on a timely basis,
- Sandia and its entire control group cease to maintain any group health plan,
- A qualified beneficiary begins coverage under another group health plan after electing continuation coverage under Sandia, and that plan does not impose an exclusion or limitation affecting a pre-existing condition of the qualified beneficiary,
- A qualified beneficiary becomes covered by Medicare (in which case the non-Medicare dependents have the right to continue their coverage for the remainder of the continuation time period), or
- A qualified beneficiary engages in conduct that would justify the Sandia Health Benefits Plan for Employees in terminating coverage of a similarly situated active employee not receiving continuation coverage (such as fraud).

Disability Extension and Multiple Qualifying Events

COBRA coverage may be extended under the following circumstances:

- If a qualified beneficiary is Social Security disabled before or during the first 60 days of an 18-month COBRA period, all of the individual's COBRA-eligible family is eligible for an 11-month extension of coverage up to a maximum of 29 months from the original COBRA qualifying event date. After the first 18 months of COBRA coverage, he/she will be charged 150 percent of the cost of the applicable group rate (102% for Kaiser).
- The individual must provide a copy of the Social Security disability determination to the COBRA Administrator within 60 days of the date the disability determination was made and no later than 18 months after the election change event. He/she must also provide

notice within 30 days of determination that the qualified beneficiary is no longer disabled.

- When the qualifying event is termination of employment, and as a qualified beneficiary, you experience a second qualifying event such as the death of the primary qualified beneficiary, the divorce or legal separation from the primary qualified beneficiary, the primary qualified beneficiary becoming entitled to Medicare, or a loss of dependent child status under the Sandia Health Benefits Plan for Employees, you may become entitled to an 18-month extension of your COBRA coverage (for a total maximum period of 36 months of continuation coverage). For example, if an employee terminates and subsequently gets a divorce five (5) months later, COBRA continuation coverage for his ex-spouse can last up to an additional 31 months (36 months minus 5 months). If a second qualifying event occurs, you will need to notify the COBRA Administrator.
- When the qualifying event is termination of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). You will need to notify the COBRA Administrator of this.

Special COBRA Rights for Kaiser Members

If you are enrolled in the Kaiser HMO at the time your COBRA coverage through Sandia ends, you and your eligible dependents may be eligible to extend COBRA coverage from 18 or 29 months to a total of 36 months measured from the date of the original qualifying event through Cal-COBRA. Kaiser may charge up to 110% of the cost (disabled individuals may be charged up to 150% of the cost).

This special California continuation benefit is provided by Kaiser and is not Sandia's responsibility. To continue under Cal-COBRA, you need to apply directly to Kaiser at 1-800-464-4000.

Converting Coverage After Termination

If you are enrolled in Kaiser, you may be eligible to convert your coverage to an individual policy at the end of your COBRA period. Refer to the Kaiser HMO Program Summary for information on converting to an individual policy. The cost of conversion coverage is usually high, and conversion coverage often will not offer the same comprehensive coverage as what you currently have. For more information about conversion rights, contact Kaiser directly. There are no conversion policies for the self-funded health Programs.

Contact Information

If you have any questions about COBRA coverage or the application of the law, please contact: HBE Customer Service (505) 844-HBES (4237)

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep Sandia informed of any changes in your and your family members' addresses. You should also keep a copy, for your records, of any notices you send to Sandia.

Section 11. Your Rights under ERISA

As a participant in the Sandia Health Benefits Plan for Employees, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue group health plan coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for one year (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or

any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court, after exhausting the plan's claims and appeals procedures. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a Federal court, after exhausting the plan's claims and appeals procedures.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator listed in Appendix D of this document. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Section 12. Definitions

Please note that certain capitalized words in this SPD have special meanings. These words have been defined in this section. You can refer to this section as you read this document to have a clearer understanding of your benefits.

Adverse decision/adverse benefit	A denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit.
Certificate of Creditable Coverage	A certificate of creditable coverage is a written document that shows your prior periods of coverage in a health plan. The certificate must be furnished automatically to an individual whose group coverage has ended, such as when they leave or quit a job; an individual who loses health coverage and who is not entitled to elect COBRA continuation of coverage; and an individual who is qualified for COBRA and has elected COBRA continuation coverage or after the expiration of any grace period for the payment of COBRA premiums.
CHIP	Childrens Health Insurance Program
Class II Dependent	Unmarried child over the age of 23; unmarried stepchild; unmarried grandchild; unmarried brother or sister; parent or spouse's parent, step-parent or grandparent.
Dual Sandian	Both spouses or same-gender domestic partners are employed by or retired from Sandia.
HBE	Health, Benefits, and Employee Services
HMO	Health Maintenance Organization
Living with You	A person living in your home at least 50% of the year. Stepchildren visiting for the summer are not considered to be living with you.
Long Term Disability Terminee	A former employee who has been approved for and is receiving disability benefits under either Sandia's Long Term Disability Plan or Sandia's Long Term Disability Plus Plan.

Non-Qualifying Dependent	A dependent who does not meet the definition of a qualifying child or qualifying relative under Internal Revenue Service Publication 502.
Post-Secondary Educational Program	Students who are classified as Graduate, Professional Administrative or Co-op; Graduate Engineering Minorities; Undergraduate Co-op, General Clerical, Technical or Business; and General Laborer.
Primary Covered Member	The person for whom the coverage is issued; that is, the Sandia employee, retiree, survivor, or the individual who is purchasing temporary continued coverage.
Primary Coverage	The health plan that has the legal obligation to pay first when more than one health plan is involved.
Qualifying Event	Under COBRA, an event that but for the COBRA requirements would result in the loss of coverage to a qualified beneficiary.
Qualified Medical Child Support Order (QMCSO)	See Section 3, Eligibility Information.
Rehire	Refer to the booklets entitled "Retirement Income Summary Plan Description" or "Pension Security Plan Summary Plan Description".
Retire/retirement	Refer to the booklet entitled "Sandia Health Benefits Plan for Retirees Summary Plan Description".
Service Area	The geographical or other area to which a benefit Program is limited, within which participating providers are accessible to members. For example, an HMO service area or the on-site medical clinic limitation of use to active employees.
Spouse	Your lawful husband or wife as defined by federal law.
Surviving Spouse/Surviving Dependents	An enrolled spouse or enrolled dependent of an on-roll regular employee or a Sandia retiree who dies while covered under one of the medical Programs.

Appendix A. Program Summary Materials

The following supplemental Benefit Program Materials, together with any updates (including any Summary of Material Modifications (SMMs) and open enrollment materials, are hereby incorporated by reference into the SPD and the Plan.

Program	Program Material
UnitedHealthcare Standard PPO Program	http://www.sandia.gov/resources/emp-ret/spd/index.html
UnitedHealthcare Premier PPO Program	http://www.sandia.gov/resources/emp-ret/spd/index.html
CIGNA In-Network Program	http://www.sandia.gov/resources/emp-ret/spd/index.html
Kaiser HMO (California only)	http://www.sandia.gov/resources/emp-ret/spd/index.html
Dental Care Program	http://www.sandia.gov/resources/emp-ret/spd/index.html
Vision Care Program	http://www.sandia.gov/resources/emp-ret/spd/index.html

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Appendix B. Claims and Appeals Administrative Information

Send all claims and claim appeals for benefits to the Claims Administrator as outlined in this Section. As the claims fiduciary, determinations by the Claims Administrator shall be conclusive and not subject to review by Sandia.

Program	Group Number	Claims Administrator
UnitedHealthcare Standard PPO Program	708576	**UnitedHealthcare Claims Address:** UnitedHealthcare P.O. Box 740809 Atlanta, GA 30374-0809 **UnitedHealthcare Appeals Address:** UnitedHealthcare – Appeals P.O. Box 3043 Salt Lake City, UT 84130-0432 877-835-9855 www.myuhc.com **Catalyst Rx Claims/Appeals Address:** Catalyst Rx P.O. Box 1069 Rockville, MD 20849-1069 866-854-8851 www.catalystrx.com
UnitedHealthcare Premier PPO Program	708576	**UnitedHealthcare Claims Address:** UnitedHealthcare P.O. Box 740809 Atlanta, GA 30374-0809 **UnitedHealthcare Appeals Address:** UnitedHealthcare – Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432 877-835-9855 www.myuhc.com **Catalyst Rx Claims/Appeals Address:** Catalyst Rx P.O. Box 1069 Rockville, MD 20849-1069 866-854-8851 www.catalystrx.com

Program	Group Number	Claims Administrator
CIGNA In-Network Program	3172368	**CIGNA Claims Address:** P.O. Box 182223 Chattanooga, TN 37422-7223 **CIGNA Appeals Address:** CIGNA HealthCare Appeals Department 700 N. Brand Blvd. Glendale, CA 91203 800-244-6224 www.mycigna.com **Catalyst Rx Claims/Appeals Address:** Catalyst Rx P.O. Box 1069 Rockville, MD 20849-1069 866-854-8851 www.catalystrx.com
Kaiser HMO (CA)	7455	**Claims Address** Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 12923 Oakland, CA 94604-2923 **Appeals Address:** Kaiser Permanente Special Services Unit P.O. Box 23280 Oakland, CA 94623 800-464-4000 www.kp.org
Dental Care Program	9550	**Claims Address:** Delta Dental P.O. Box 9085 Farmington Hills, MI 48333-9085 **Appeals Address:** Customer and Claims Services Department or Dental Director Delta Dental P.O. Box 30416 Lansing, MI 48909-7916 800-264-2818 www.toolkitsonline.com

Program	Group Number	Claims Administrator
Vision Care Program	None	**Claims Address:** Davis Vision Care Processing Unit P.O. Box 1525 Latham, NY 12110 **Appeals Address:** Davis Vision Care Processing Unit Attn: Appeals Department P.O. Box 1525 Latham, NY 12110 888-575-0191 www.davisvision.com

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Appendix C. Funding and Contract Administration Information

Program	Contract Address	Insured/Self-Insured
UnitedHealthcare Standard PPO	UnitedHealthcare 425 Market St. San Francisco, CA 94105-2483 Catalyst Rx Inc. 800 King Farm Blvd. Suite 400 Rockville, MD 20850-6105	Self-Insured
UnitedHealthcare Premier PPO	UnitedHealthcare 425 Market St. San Francisco, CA 94105-2483 Catalyst Rx Inc. 800 King Farm Blvd. Suite 400 Rockville, MD 20850-6105	Self-Insured
CIGNA In-Network Program	CIGNA Healthcare 3900 E. Mexico Avenue Denver, CO 80210	Self-Insured
Kaiser HMO (CA)	Kaiser Foundation Health Plan, Inc. 1350 Treat Blvd. Walnut Creek, CA 94596-2174	Insured
Dental Care Program	Delta Dental of New Mexico 2500 Louisiana Blvd. N.E. Suite 600 Albuquerque, NM 87110	Self-Insured
Vision Care Program	Davis Vision Inc. 150 Express Street Plainview, NY 11803	Self-Insured

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Appendix D. Plan Administration Information

What	Who
Official Plan Name	Sandia Health Benefits Plan for Employees (Refer to Appendix A of this document for a listing of Benefit Programs applicable to this SPD)
Employer/Plan Sponsor	Sandia Corporation 1515 Eubank S.E. Albuquerque, NM 87123
Employer I.D. Number (EIN)	85-0097942
Plan Number	540
Type of Plan	The Sandia Health Benefits Plan for Employees is a welfare benefit plan which includes medical, dental, and vision benefits.
Plan Funding Medium	The insurance arrangements are paid by insurance policies. The benefits and other costs (such as administrative costs) for the self-funded Programs are paid from the general assets of Sandia Corporation.
Plan Administrator	Sandia Corporation c/o Benefits Department Physical address: 1611 Innovation Parkway S.E. Albuquerque, New Mexico Mailing address: 1515 Eubank S.E. Albuquerque, NM 87123-1463 OR P.O. Box 5800 Albuquerque, NM 87185-1463 (505) 844-5677
Claims Administrator	Refer to Appendix B of this document
Agent for Service of Legal Process	Corporation Service Company (CSC) 2711 Centerville Road, Suite 400 Wilmington, DE 19808 OR 125 Lincoln Avenue, Suite 223 Santa Fe, NM 87501 (505) 989-7500 OR 2730 Gateway Oaks Drive, #100 Sacramento, CA 95833 (916-641-5100)

What	Who
	Service of legal process also may be made upon the Plan Administrator as follows: Sandia Legal Division Sandia Corporation 1515 Eubank SE MS0141 Albuquerque, NM 87123. OR P.O. Box 5800 MS0141 Albuquerque, NM 87185
Plan Year	January 1 – December 31
Contribution Sources	Sandia Corporation and participant contributions
Union Agreements	For represented employees, the welfare benefits described in the Summary Plan Description booklets reflect the provisions of the plans that have been and are currently subject to negotiations between Sandia and the various unions representing Sandia employees. Copies of collective bargaining agreements referring to the plans are distributed or made available to employees covered by such agreements and may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and are available for examination by participants and beneficiaries as described in section entitled Your Rights Under ERISA of this Summary Plan Description. The effective date of the plans for employees in each bargaining unit is the date specified in the applicable union agreement.